

# Summaries of Country Experiences on Primary Health Care Revitalization

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*Towards the Achievement of the Health  
Millennium Development Goals*



AFRICAN DEVELOPMENT  
BANK GROUP

**International Conference on Primary Health Care  
and Health Systems in Africa: Towards the  
Achievement of the Health Millennium Development  
Goals**

**Summaries of Country Experiences on Primary Health Care  
Revitalization**

## **EXECUTIVE SUMMARY**

By memorandum dated 5 July 2007, the WHO Regional Office for Africa requested countries of the Region to share their experiences in primary health care strategy implementation. By the time of writing this report, contributions had been received from 42 of the 46 Member States of the Region. Countries were asked how the PHC concepts are understood, how appropriate they are to their national context, how the PHC approach has addressed equity in access to quality health care, and whether PHC is implemented in an integrated manner. They were also asked if PHC contributes to community involvement in health matters, what the main constraints affecting PHC programme implementation are and what are their suggestions, based on country experiences and successful examples, to address these challenges.

The summaries of country contributions based on their responses are grouped under three items:

- (i) The PHC concepts: their understanding and appropriateness to the national context and health policies;
- (ii) Actions taken to revitalize PHC; and
- (iii) Challenges for PHC implementation and recommendations.

**March 2008**

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## **ANGOLA**

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

In Angola, the PHC approach is understood as a strategy to provide essential and affordable health care to the population at community, health post, health centre and municipal hospital levels, with the consent and participation of the communities themselves. It comprises curative, preventive, promotive and rehabilitative care. The PHC approach is adopted by the government and is used in the formulation of sectoral policies and health strategies. PHC principles are also reflected in a number of articles of the country's Constitution.

There are three distinctive periods in PHC development in the country: **1975-1980**, when PHC was implemented through health and community workers (community workers were involved in health even before the PHC declaration!); **1980-2002**, when community workers were trained in priority PHC interventions and renamed health promoters (public health sector promoters were trained to provide health education and ensure the referral of patients; Catholic Church health promoters were trained in health education and curative care). During the second period, health care was free for all and the principle of equity was prominent with equitable access to care. Health service utilization also improved as a result of the decentralization of services. However, both periods were affected by the long-drawn-out civil war. The period **2002-2007** was marked by profound changes, with the privatization of health services and payment for health care. During this period all gains in equity were lost. The poor turned to traditional healers or treated themselves at home.

Despite the government's effort over the past five years, maternal and child mortality levels remain very high and the quality of health care has declined. The absence of national health development policies and strategic plan as well as the non-existence of norms and standards on health infrastructure, medical equipment and health personnel directly or indirectly affect PHC implementation in the country.

### **2. Actions taken to revitalize PHC**

The government embarked on the decentralization of health services throughout the country to bring the services closer to the population. The utilization of health services improved and the number of partners supporting the health sector increased. In 2004, the ministry of health

organized a national workshop on the municipal health system to identify constraints facing the system and reorient health workers towards solving these constraints. The workshop also addressed problems of coordination within the municipal health system and with partners in health.

Special efforts were made by the ministry in maternal and child health. The “National strategy to accelerate the reduction of maternal and infant mortality during the period 2005-2009” was adopted, in line with the WHO Regional Committee’s resolution (2006) on revitalizing PHC. In collaboration with the partners, the government initiated three-phase pilot projects (2007-2009; 2010-2011; 2012-2013) on the revitalization of health services using the PHC approach. This initiative, which covers five provinces, will be expanded to other provinces depending on its results. The integration of PHC has been partial covering certain priority interventions while some disease control programmes are implemented vertically.

### **3. Challenges for PHC implementation and recommendations**

- (i) The socioeconomic consequences of the war were tremendous: 70% of health infrastructure was destroyed; the war affected the availability of human resources and accessibility to health care especially at the peripheral level and for hard-to-reach populations. The government has to mitigate these consequences of the war.
- (ii) A national strategic plan on health development should be drawn up to orient health managers, other staff and community members towards PHC.
- (iii) Community involvement has, to some extent, declined and there is a need to strengthen it. Health management committees should therefore be set up at operational level to reinforce linkages between communities and health providers.
- (iv) It is necessary to formulate a human resource development policy incorporating the reinforcement of training schools, proper placement of graduates, improved working conditions and remuneration schemes.
- (v) There is a need to set health personnel, infrastructure and medical equipment standards and norms, including a minimum package of essential interventions at operational level.
- (vi) Health information systems at national and especially operational (municipal) levels are weak.
- (vii) There is a need to improve collaboration between the private and public sectors.

- (viii) Intersectoral and intrasectoral collaboration for health is weak and should be substantially reinforced.
- (ix) Mechanisms for partner coordination have not been put in place. There is therefore a need to establish a coordination framework.
- (x) It is important to promote integration among various programmes. Individual programmes should be used as entry points for their integration.

## **BENIN**

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

PHC is viewed as health care universally accessible to all individuals, families and communities at affordable cost and with their full participation. The PHC strategy (reaffirmed later on by the Bamako Initiative) was adopted to bring health care closer to the population. The organization of PHC systems was not specifically clarified and it was up to each country to establish strategies taking into account its geographical, socio-cultural and economic realities. The focus was on availability of medicines which were scarce in the 1970s due to their high cost. With the introduction of the PHC approach, the availability of drugs improved as their selection was done according to health priorities in affected locations.

An outreach strategy for disease prevention and immunization is adopted in areas located at more than 5km from health centres. An integrated approach was implemented during outreach visits, with the provision of pre- and post-natal consultations for and distribution of chloroquine, iron and mebendazole to pregnant women. Children are also administered the oral rehydration solution (ORS) and mebendazole. Infant immunizations are accompanied by the distribution of vitamin A capsules. Equity in health is assured by establishing standardized disease treatment protocols and applying fixed fees for services. To ensure community participation in health, management committees have been established at all health facilities for planning, budgeting and monitoring activities. Committee members include community leaders, representatives of women's groups and persons involved in activities including research. Health facility staff provides feedback on results achieved annually.

## **2. Actions taken to revitalize PHC**

The introduction of the Bamako Initiative revitalized PHC by giving decision-making powers to health zones (districts). It also provided the opportunity to establish the “minimum health package” to be delivered by peripheral health units. A policy to reform the zonal (district) health system was developed in 1995; it provides for zonal hospitals and reference centres. Health sector financing has also been improved through better management of national health accounts and the introduction of a policy of contracting out services. A 2007-2016 national health development plan and a strategic plan for the development of human resources for health are under preparation. They will include strategies to revitalize PHC implementation.

## **3. Challenges for PHC implementation and recommendations**

- (i) Low motivation of community representatives (village chiefs, women’s groups, etc.) to participate in health activities.
- (ii) The running cost of community health services should be shared with the community. This will boost the expansion of services and collection of revenues to cover operational costs at local level (e.g. the cost of essential drugs, salaries of local health workers in order to motivate them and support other community health activities). Community members may also pay for services provided to them by their work (“work for service”) or make direct payment to the health facility.
- (iii) Vigorous promotional work for availability of essential drugs should be carried out to ensure their accessibility, quality and affordability at low cost.
- (iv) Communities should be responsible for community health management. Funds generated through community financing mechanisms should not be paid into the public treasury. They should instead be credited to a local community account to be managed by the Management Committee.
- (v) The motivation of community health workers is low as the majority of them work without adequate resource support from either the communities they serve or from the health care system.
- (vi) The supervision of personnel and their training/retraining in community health are inadequate and should be reinforced.

## **BURKINA FASO**

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

PHC is recognized as a logical product of health policy which has undergone various steps in the course of implementation, depending on the national and international political environment as well as economic and social development. PHC strategies, which are influenced by these factors, were regularly reformulated and refocused.

The 1980-1990 National Health Programme (NHP) that was developed just after the Alma-Ata Conference was a major step in PHC programme development in the country. The programme and subsequent strategies and strategic plans were inspired by the PHC concepts. The NHP has been operationalized, based on a series of other short-term documents and five-year plans which embodied specific actions in PHC development. According to these documents, a health post - the first level in the entire referral chain - has been established in each village in the country. Social and health promotion centres, together with zonal medical centres, were also created to deliver curative and preventive services and promote community health.

The 2001-2010 National Health Development Plan was a logical successor of the NHP, providing guidance for the management of PHC in the next decade during which health reforms were envisaged to promote decentralization and progressive changes within hospital and pharmaceutical services. Since then, decentralization has been especially effective in the management of the control of endemic and epidemic prone diseases and the emergencies created by them. The new strategic document also underlined the role of local communities in implementing health programmes.

### **2. Actions taken to revitalize PHC**

In 1993, the government in collaboration with its partners, developed a national strategy for the reinforcement of PHC with the aim of facilitating the implementation of the Bamako Initiative. Some 53 health districts were set up to decentralize technical support for the management of hospitals and peripheral health facilities as well as to ensure community participation through management committees.

The drug procurement procedure has been centralized to ensure that the quality of essential drugs is not compromised. Drug depots were also created at district and health facility levels to prevent the disruption of drug supplies to health facilities. As a result of the delegation of authority in financing, the districts were allowed to keep money locally collected through user fees and part of the “drug” money for the running costs of health services or for staff motivation. The district operationalization process was also marked by the creation of a minimum package of activities for health centres and a complementary package for district hospitals.

A new national health policy and action plan based on the policy were formulated in 2000 covering the period 2001-2010. The action plan was broken up into short-term plans. The key policy issues and the plans include improved health coverage and quality of care, development of human resources, activities to increase the financial resources of the health sector and to build the institutional capacity of the ministry of health, training of health staff and reduction of HIV transmission and the communicable disease burden. These documents address important challenges affecting the country’s ability to achieve the Millennium Development Goals and poverty reduction targets and other challenges by the international community. A mid-term evaluation of the national health development plan was conducted in 2005. It documented some progress in development of district health systems and significant improvements in access by the population to basic health care.

### **3. Challenges for PHC implementation and recommendations**

- (i) Morbidity and mortality from HIV/AIDS and other priority diseases and conditions (malaria, tuberculosis, measles, neonatal tetanus, acute diarrhoeal episodes, malnutrition, etc.) remain high. There are frequent epidemics and outbreaks of some of these diseases (meningitis, yellow fever, cholera, etc.). In addition, there is a need to strengthen the control of neglected and chronic diseases such as onchocerciasis, lymphatic filariasis, drepanocytosis, diabetes, cancer and arterial hypertension. Accelerated actions are required in the family planning, emergency obstetric and neonatal care, integrated disease control (e.g. IMCI) and other programme areas.
- (ii) There is an urgent need to strengthen the implementation of the national human resources plan for health development.
- (iii) It is essential to improve coordination among health service support programmes (logistics and equipment, drug and laboratory supplies and maintenance of health infrastructure).

- (iv) It is necessary to build the institutional and technical capacities of central, regional and district health systems and facilities.
- (v) Financial barriers should be removed to improve equity in access to health services.
- (vi) Targeted actions are needed to reinforce interventions at community level.
- (vii) It is essential to improve the coordination of knowledge production and management, including national health research.

## **BURUNDI**

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

There is a high political commitment to primary health care (PHC) in the country. PHC is seen as a package of essential health care universally acceptable to individuals, families and communities with their full participation and at affordable cost at all levels. It is an integral part of the national health system, contributing to economic and social development of communities. It has eight components as outlined in the Alma-Ata Declaration. The PHC approach is implemented through five strategies as follows: decentralization of services and intersectoral collaboration; equity; integration of health services; improvement of quality of services; and community participation.

The national health policy has taken into consideration PHC elements, linking them with the health priorities of the country. However, its implementation strategies were not always successful due to organizational and structural constraints. For this reason, the National Health Programme 2005-2015 and National Health Development Plan 2006-2009 introduced health reforms based on the district health system. The issue of equity was always the centre of Government's attention and there was a high political commitment to it. The health policy advocates a number of measures to address equity in health. These include subsidies for the care of pregnant women and children under five years of age, provision of free ARV drugs to HIV-infected persons, as well as for the treatment of patients with tuberculosis and malaria.

The policy of integration of health interventions has a prominent place in PHC implementation and is one of the cornerstones of the health reform process. It has been carried out by integrating various priority interventions into the minimum health package: infant immunization, Integrated Management of Childhood Illness (IMCI), provision of vitamin A, micronutrients and deworming drugs, etc.

The health development policy encourages communities to participate in health programmes through health committees, management committees and community health workers. The community members take part in micro-planning, health centre management, social mobilization of the population, epidemic control as well as in the construction of health facilities and infrastructure development. There is always social dialogue on the results and ways of participation, quality of work done by the community members, use of collected funds and on the control of local authorities over health service provision. The geographic access of the population to health services is one of the highest in sub-Saharan Africa, reaching 80% (five km or one hour walking distance to the nearest health centre).

## **2. Actions taken to revitalize PHC**

Implementation of the National Health Programme 2005-2015 and National Health Development Plan 2006-2010 played an important role in developing health systems and programmes in the country. Most of the priority programmes have developed policies and strategies in line with the following strategic areas: HIV/AIDS, Malaria Control, Reproductive Health, Tuberculosis, Expanded Programme on Immunization (EPI), IMCI, Nutrition, Mental Health, Essential Drugs, Traditional Medicine, etc.

In 2006, a presidential decree announced free health care for pregnant women and children under five years of age which substantially increased the utilization of services and promoted equity in health. There is an established community-based system to identify poor people on the basis of locally defined criteria for provision of free or subsidized care. There is a national solidarity fund which provides financial resources for free HIV and TB tests for all people. HIV/AIDS drugs and medical equipment are exempted from tax. Low-cost malaria drugs are available universally.

Considerable efforts were made by the Government to improve environmental health, focusing on the provision of drinking water and sanitation. The Government also established a four-hour working time on Saturdays to be devoted to improving hygiene and sanitation in the communities. With the participation of the communities, an obstetric emergencies programme was established in six provinces targeting the reduction of maternal and neonatal mortality. Two new vaccines were added to the EPI schedule (HepB and Hib) with a coverage reaching 92% in 2006.

### **3. Challenges for PHC implementation and recommendations**

- (i) The proportion of the national budget allocated to health is very small (4.7% in 2006), which affects the implementation of large-scale community programmes.
- (ii) Although the Government subsidizes the delivery of some health care, the direct costs of other services not subsidized by this option are too high.
- (iii) Government drug stores, hospitals and health centres frequently run out of some priority drugs.
- (iv) There is a need to improve the quality of health care to boost user confidence in the health system.
- (v) There is a need to improve access by the population to drinking water and sanitation facilities.
- (vi) Health and management committees (as well as community health workers) have been established across the country, but they are hardly functional. They need to be revitalized.
- (vii) Acute and chronic malnutrition indicators are very high (7.4% and 52.5% respectively in 2005), indicating the need for reinforcement of the PHC food supply and nutrition component.

## **CAMEROON**

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

The PHC approach was adopted in 1982 with the objective that “by the year 2000 all people in Cameroon will attain a level of health which will enable them to enjoy socially and economically productive life”. The implementation strategy was village-based with a system comprising a health committee, a management committee, a village pharmacy and a number of community health workers and traditional healers. The historical evolution of PHC indicates that the present district-based health system has reoriented the health sector towards a PHC system that is integrated but which also includes some vertical programmes.

Community participation in PHC activities in the country is universal but the degree of participation varies according to province. It is high in the North-West, South-West and Littoral provinces. Integrated health centre coverage in the country now stands at 80%. In 1988, an evaluation was conducted to document the viability of this system which revealed certain problems in the referral system related to the continuum of care.

### **2. Actions taken to revitalize PHC**

In 1997, the President of the Republic launched a poverty alleviation project which was evidence of high political commitment to all development sectors including health. Such commitment generated enthusiasm among health authorities who initiated a health reform process embodied in the 2001-2010 health sector strategy document. The reform announced the reorganization of the sector by strengthening its capacity and management, improving health service delivery including quality and accessibility of essential drugs, decentralization of services and improvement of health sector financing.

All levels of the health system had to coordinate PHC activities. The mid-term evaluation of the strategy revealed some improvements in accessibility of the population to essential drugs and the presence of dialogue within the health structures as well as their participation in sector programming. A new strategy was developed extending the period of action up to 2015 with the objective of meeting the MDG targets.

### **3. Challenges for PHC implementation and recommendations**

- (i) Community participation in health matters is insufficient, especially in urban areas.
- (ii) Human resources are inadequate in terms of number and quality.
- (iii) Some programmes are still using the vertical approach not only at the national level but also at the district level to deliver activities.
- (iv) There is no legal and operational framework for collaboration between traditional and modern medicine.
- (v) Coordination and co-management in the health sector at all levels are poor.
- (vi) Motivation of health personnel is low because of poor working conditions and remuneration.
- (vii) Low financial accessibility of the population is a major barrier to health care.

## **CAPE VERDE**

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

Since 1976, health policy and strategy development in the country has been based on PHC principles which include decentralization and expansion of health services, free health care and care for vulnerable population groups such as women, infants and persons with chronic diseases. Other relevant principles are the integration of health services provision, intersectoral collaboration and community participation. The country's 1980 Constitution regarded health as the psycho-social well-being of the population. It prioritized the prevention aspects of health care. The PHC principles were in line with the series of national development plans (1982-85; 1986-90; 1991-95 and 1996-2000) reaffirming the need for service expansion and provision of preferential care to populations at risk. The plans also envisaged the integration of health programmes and opted for the reduction of the number of vertical programmes.

Following the 2004 evaluation of the health system, the National Health Service was restructured to reinforce the integration of health services and interventions as well as the role of the private sector in the public health system. The evaluation also underlined the importance of preventive aspects of health care delivery as well as equity and universal access to health care.

## **2. Actions taken to revitalize PHC**

PHC principles are incorporated in the 1976 national health strategy which advocates the expansion of local health services, free health care, integration of services, intersectoral collaboration and community participation. Since then several national development plans incorporating PHC principles have been formulated to further expand health coverage, integrate services and develop human resources for health. A Public Health Coordination Office was established to ensure decentralization and integration of PHC elements in health planning at local (municipal) level.

There is significant partner support in health provided by WHO, UNICEF, UNDP, UNFPA, bilateral partners and international NGOs. In 1989, a national health system regulatory document was issued wherein the PHC principles were clearly spelled out, namely: universal access, community participation, intersectoral collaboration, among others. The publication of a new document in 2004 (Lei n.º41/IV/2004 de 5 de Abril) reaffirmed the country's commitment to the same principles. However, the need to adapt to new exigencies, that is skilled staff and integration of PHC and secondary care at the district level (regions) was recognized.

The national pharmaceutical policy was approved in 2003 and the national essential drugs list is revised every two years. Essential care is implemented at the local level, with an overall coverage estimated at above 80%. For some services such as EPI and prenatal care, the national coverage rates are estimated to be around 90%. In 2004, the government instituted the “periphery allowance” for physicians and nurses.

## **3. Challenges for PHC implementation and recommendations**

- (i) Increase the capacity of the national health system at local level.
- (ii) Reinforce the integration of PHC programmes and components.
- (iii) Involve the private sector in PHC activities.
- (iv) Urge national authorities and partners to increase resource mobilization efforts to finance priority PHC programmes.
- (v) Train health personnel and create attractive career development schemes.
- (vi) Put in place an effective operational planning system including monitoring and evaluation.

## **CENTRAL AFRICAN REPUBLIC**

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

At independence, the health policy of the country was characterized by free health care (with emphasis on curative care), over-concentration of health infrastructure in urban areas, vertical approach to the control of endemic diseases, absence of community participation in health and health financing, and lack of resources for the health sector. This policy could not be sustained due to increasing health care needs and population growth. The country therefore adopted the Alma-Ata Declaration on PHC as an essential health care approach universally acceptable to individuals, families and communities with their full participation and at affordable cost. PHC formed an integral part of the country's health system, being its central function and main focus, and the overall socioeconomic development of the community. It is the first level of contact of the people with the national health system, bringing health care where people live and being the first element of a continuing health care process.

Several international initiatives and declarations have played a significant role in reorienting the country's health system towards the PHC strategy. They include: Alma-Ata Declaration (1978), adoption of the "Three-Phase Health Development Scenario " by a resolution of the WHO African Regional Committee (Lusaka, 1985), Declaration by OAU Heads of State (1987) proclaiming health as central to development, and adoption of the Bamako Initiative (1987).

### **2. Actions taken to revitalize PHC**

On the national front, the following activities were undertaken to revitalize PHC implementation: (a) A national seminar was held in 1988 which recorded slow progress in PHC implementation and recommended the acceleration of the implementation process countrywide; (b) In 1989, a statutory instrument (No. 89.003) was issued to engage the participation of communities in the PHC approach; (d) In 1992, a conceptual framework on PHC implementation was adopted; (e) In 1994 a national health policy was formulated based on PHC and Bamako Initiative principles followed by the drafting and approval of the first national health development plan; (f) The national health policy was revised in 2004 to include new orientations and developments in the PHC strategy; (g) In 2005, the second national health development plan 2006-2015 was prepared to boost PHC implementation in the country in order to attain health millennium development goals. These initiatives illustrated the government's commitment to PHC principles.

The communities were also encouraged and their participation in a number of initiatives and health projects increased. These include the Ouham, Ouham-Pende`, Nana-Gre`bizi, and Basse-Kotto district health projects. Multilateral partners contributed to PHC revitalization through technical assistance and financial support (UNICEF, WHO, UNDP, WB, EU). Bilateral partners and NGOs, such as GTZ, COOPI, French Cooperation, ASSOMESCA, OXFAM ACABEF, etc., were also among supporters of PHC implementation in the country. One of the significant outcomes of PHC implementation is the availability of drugs throughout the country.

### **3. Challenges for PHC implementation and recommendations**

- (i) Inadequate resource allocation by the government to the health sector (especially for remote areas) and poor management of funds generated from cost-recovery schemes.
- (ii) Misinterpretation of PHC and Bamako Initiative principles by management committees which prioritize profit over quality of care and are insensitive to some vulnerable population groups (destitute people, patients in need of emergency health care, etc.).
- (iii) Insufficient integration of essential health care programmes at peripheral level.
- (iv) Military and socio-political crises cause considerable damage to health infrastructure and discourage the population from participating in local health initiatives. They also impact on partner support as some partners abandon or interrupt their assistance to the health sector.
- (v) There is a great need to implement the current health development plan inspired by the Poverty Reduction Strategy Paper, especially in the following crucial areas: strengthening of health systems; operationalizing district health systems; reestablishing dialogue with management structures; and strengthening the capacities of hospitals and peripheral health centres for implementation of the minimum health activity package concept.

## **COMOROS**

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

The formulation of the national health development plan signalled health system reform in the country to the year 2010. The plan prioritized following four important PHC strategies to bring health services closer to the population: reinforcement of the district health system; decentralization of activities; provision of essential drugs; and cost-recovery. A review of the implementation of the plan in 2001 revealed weaknesses in the achievement of the objectives of the plan.

The Government soon embarked on the formulation of the 2005-2015 national health development policy as well as the national drug policy. According to the health policy, three levels of the health system are operational: central (with a national referral hospital), intermediate (regional hospitals in three islands) and district (district health centre and a number of health posts). The communities participate in health programmes through the Administrative Council, members of which are elected from the communities. The Administrative Council is the forum where the district administration and community members meet to discuss health issues.

### **2. Actions taken to revitalize PHC**

The health reform process started with the formulation of the 1994-2010 national health development plan which was reviewed in 2001. The review revealed a number of implementation problems and challenges. A 2005-2015 national health policy was also developed to enable the country to achieve the MDGs.

The country made encouraging progress in the development of health infrastructure and human resources for health. A revised drug policy was prepared in 2004. Health management committees are established at health centres and health posts. A strong cost-recovery system has been put in place and it contributes significantly (64%) to the running of the district health system.

### **3. Challenges for PHC implementation and recommendations**

- (i) The 2005-2015 national health policy needs to be operationalized by developing mid-term plans with operational targets aimed at achieving the MDGs.
- (ii) Financial contribution by the central health budget to the district health system is low (about 2%) indicating the need to increase political commitment by the health authorities to community health.
- (iii) Improve essential drug accessibility by enhancing the managerial process at all levels and making drugs affordable.
- (iv) Despite the significant progress in developing human resources for health, staff distribution in the country among the three islands is not equal, which affects equity in health provision by health professionals.
- (v) Reinforce the health information system at all levels and establish a database to be updated regularly.
- (vi) A rapid assessment of the district health system revealed that there are deficiencies at the level of health facilities in staffing (only 8% of district health centres and 15% of health posts had the required staff complement), supply of equipment (non of the district health centres and only 8% of health posts are well-equipped), availability of essential drugs (out-of-stock episodes were mentioned by all district health centres and health post staff) and electricity and water supply, etc., which affect the utilization of available services (0.19 visits per person/year; only 29% of deliveries take place at peripheral health facilities). It was also observed that health facilities were unable to provide all the components of the minimum health activity package to clients.
- (vii) The functionality of most management committees is low. There is therefore an urgent need to reinforce this important structure in order to optimize health care provision to the population.

## **CONGO (DRC)**

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

Congo's definition of PHC is in line with the Alma-Ata Declaration and incorporates essential care geographically and financially accessible to all with the full participation of communities. It comprises the eight elements of PHC defined in the Declaration. In addition, it includes three more elements which are specific to the DRC: the managerial process, continuing education and mental health programme.

In 1978, the DRC subscribed to the African Development Charter which was one of the first steps towards establishing PHC in the country. The Central Committee of the ruling party confirmed its commitment to the PHC approach. These developments opened the door to other initiatives which reinforced the full introduction of the PHC strategy into the health system. This increased accessibility to health care, community participation and equity. Since then, the PHC concepts have continued to have pride of place in the country's health policy and strategic plans.

The main PHC delivery strategy is integration which brings together eight generic elements defined in the Alma-Ata Declaration, and another three which are country-specific. This constitutes a minimum package of activities which includes curative, preventive and promotive interventions. Community participation has and continues to play an important role in ensuring the sustainability of PHC in the country. In 1990 when all support by cooperation partners came to a halt, the viability of PHC activities was ensured by support from local NGOs and cost-recovery funds contributed by community members as service users. Community participation in PHC is realized through health committees (COSA) established in each health centre.

### **2. Actions taken to revitalize PHC**

After the adoption of the PHC strategy, the country undertook a number of activities and initiatives to implement it. The initiatives included the formulation of the health development plan 1982-86, adoption of the Partnership Charter for inter- and intrasectoral collaboration, introduction of the Bamako Initiative to mobilize community funds through cost-recovery schemes, etc. In 1999, the country reaffirmed its commitment to PHC as a basic strategy for all activities in health services. Based on this commitment, a new health policy and health development plan for the 2000-2009 period were developed. However, the implementation of the

policy and the plan was affected by the instability which persisted in the country during 1996-2003. As a result of the restructuring of the health system, 307 health districts or “health zones” were created and health and management committees established to monitor the implementation of activities.

In order to create a critical mass of health workers in public health, a Public Health School was established at Kinshasa University in 1986. It has since then trained more than 500 cadres in public health and health economics. The Bamako Initiative was adopted to involve communities in health matters and to mobilize funds (cost recovery) for strengthening health sector capacity. A minimum package of activities was established which includes priority elements of various health programmes. Community participation in health matters has improved. COSAs initiate several activities at community level: construction of health facilities and houses for staff, monitoring of patients with chronic illness, health education, etc. The Catholic and Protestant Churches are also playing a significant role in community services including health.

### **3. Challenges for PHC implementation and recommendations**

- (i) The suspension of external aid by the donor community created numerous constraints on the smooth implementation of PHC activities by health zones. The financing of activities became a serious problem. The operationality of the zonal health system and PHC programmes was ensured only thanks to the support of NGOs and cost-recovery funds generated by the communities. This clearly demonstrates the need for sustained partnerships with NGOs and communities.
- (ii) Close collaboration should also be maintained with the private sector within the framework of public/private mix as well as with the church which served as a valuable support in operationalizing most of the zonal health system (60%) during the 1985-1990 period.
- (iii) Serious constraints on the entire health sector including PHC implementation are caused by the long-drawn-out political instability and arm conflict in the country.
- (iv) In spite of the gradual increase in the proportion of the overall state budget allocated to health in recent years (from 4.5% to 7.0% in 2004-2006), the sector still remains underfinanced.

- (v) The poverty of the population is another serious concern which directly or indirectly affects PHC service utilization.
- (vi) Brain drain due to the deterioration of working conditions results in the exodus of health staff from rural health facilities to urban areas.

## **CONGO (REPUBLIC OF CONGO)**

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

The PHC approach was initiated in the country in 1970s with the Kinkala and Owando basic health services development pilot projects. Political commitment to the PHC strategy was confirmed by the Third Extraordinary Congress of the Congolese Labour Party in 1979. Priority was given to preventive health services and primary health care, including the provision of essential drugs to the population. This was followed by the formulation of the first five-year development plan (1982-1986) which emphasized the need to strengthen community health care with the support of specialized hospital services. The plan envisaged the transformation of the General Hospital of Brazzaville into a University Teaching Hospital (CHU).

During the planning period, a number of initiatives were implemented by the communities and cooperation partners. These included the distribution of drugs, provision of basic curative care, creation of health posts, rural dispensaries and pharmacies as well as the posting of rural health workers to be in charge of community health. Apart from curative care, preventive care activities were also carried out including malaria prevention, environmental sanitation, improvement of drinking water sources, etc. In spite of these activities, PHC programming in the country was not coherent until the 1990s.

### **2. Actions taken to revitalize PHC**

In May 1990, the ministry of health organized a national workshop to guide the introduction of the Bamako Initiative (BI) in the country. The workshop prepared a framework for the implementation of BI based on the national health development plan adopted in 1992. The plan proposed nine main implementation strategies as follows: promotion and protection of individual and community health; accessibility of health care and health services by all ; integration of health activities at the operational level ; involvement of private sector in health activities ;

elaboration of alternative ways to complement health financing; national capacity building in health system management ; decentralization of the country's health system; rational use of health resources; promotion of the participation of individuals and communities as well as partners in health activities. The implementation of the national health development plan resulted in the execution of various projects based on PHC principles which strengthened district health systems.

To improve health management, the country was divided into 41 health districts each having a district hospital and a network of health centres. Based on this model, the following activities were carried out during the last 15 years : (a) training of health personnel working at health districts ; (b) rehabilitation and supply of equipment to district hospitals and health centres ; (c) establishment of a centralized essential generic drug procurement and distribution facility ; (d) establishment of an essential district health package for each health facility; (e) inclusion of the operational components of some specific programmes in the district health centre package; (f) encouragement of communities to participate in the management of their health matters ; (g) institution of cost-recovery schemes at health centres and hospitals ; (f) measures to ensure proper health financing.

### **3. Challenges for PHC implementation and recommendations**

- (i) Poor quality of health service provision.
- (ii) Problems associated with lack of health personnel and their weak technical skills.
- (iii) Poor performance of centralized drug procurement which jeopardizes the availability of essential generic drugs in health facilities.
- (iv) Insufficient financial resource allocation to the health sector coupled with poor management of available resources.

## **CÔTE D'IVOIRE**

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

PHC is defined as a package of essential care, corresponding to the basic health needs of the population, offered by health providers in health facilities or at community level. The

Government adopted the PHC principles in the early 1980s and the Primary Health Care Charter was ratified by the President. The Bamako Initiative was also introduced in the country to reinforce the implementation of PHC.

The country's health policy is based on PHC strategies developed in three phases: definition and creation of the health district as an operational unit in the national health system; definition and putting in place of the minimum package of activities for each level of the health system pyramid which has rationalized the provision of curative, preventive and promotive care; and the rationalization of the health system through the establishment of district management teams to monitor activities and optimize resource utilization. This policy, which is reflected in the 1996-2005 national health development plan, is still valid and will be incorporated in the new health development plan together with the updated health information policy.

Accessibility to and equity in health care are ensured by a number of provisions such as the provision of care through established activity packages and fixed prices for each level, use of generic essential drugs and the referral system which includes a first contact health facility (rural and urban district health centres), general hospitals at the intermediate level and specialist hospitals at the central level of the health system pyramid.

Community participation in PHC activities is guided by management committees at the district level and by health and development committees at the community level. These committees ensure that activities are relevant to the local socio-economic and cultural set-up of the communities. They also monitor the utilization of health resources and election of community health workers and traditional birth attendants.

## **2. Actions taken to revitalize PHC**

The following activities are implemented to revitalize PHC: establishment of first health contact teams supported by management teams to deliver the minimum package of activities which represents a set of priority and effective interventions. The ministry of health and hygiene prioritized 21 programmes addressing the control of communicable and noncommunicable diseases. Each of these programmes has formulated integrated strategies to be implemented at the district level. A good coverage of health services throughout the country was achieved by conducting a decentralization policy and creating many community-based establishments (38) to address regional disparities.

Planning, supervision and capacity building are reinforced by district health teams. A number of reviews of community participation and equity in health were undertaken to identify ways of improving them. Training of district health workers in PHC implementation was carried out using training modules/tools, guidelines and monitoring charts.

### **3. Challenges for PHC implementation and recommendations**

- (i) There is a need to develop a PHC policy document with country specific implementation strategies.
- (ii) Halting of funding by development partners affected PHC implementation, especially training and monitoring of PHC activities.
- (iii) There are no allocations for re-launching the PHC strategy, which indicates a need for resource mobilization.
- (iv) Resources are redirected from PHC programmes to other priorities.
- (v) In order to facilitate the achievement of MDG targets for maternal and neonatal mortality, there is a need to strengthen the technical capacity of referral hospitals and maternity wards.
- (vi) An integrated strategy for infant survival should be developed to encompass the following five cost-effective interventions so as to have a greater impact on child mortality: immunization, maternal and neonatal health, IMCI, prevention of mother-to-child transmission of HIV and water and environmental sanitation.
- (vii) External partner support is essential to revitalize the implementation of the PHC strategy.
- (viii) There is a need to regularize the status of the community health worker.
- (ix) Put in place a stock of reference documents and other management tools and introduce joint management options, cost-recovery methods and incentive schemes for community workers.

## **CHAD**

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

The Government adopted the PHC principles in view of the lack of resources for health and poor health coverage especially in rural areas. The 1983 national health seminar confirmed the importance of health in community development with PHC as a core element in the development process.

In 1990, the Government initiated the restructuring of the health system by creating an organizational pyramid with the district as the basic structure within the entire health system, supported by the intermediate and central levels. The district health system includes district hospitals which provide the minimum package of activities as second-line structures and zonal health centres as first-line structures providing the minimum package of activities based on PHC components. These packages are delivered in an integrated manner which increases the cost-effectiveness of services. At community level, there are health and management committees in which community members participate. These committees select community health workers and traditional birth attendants according to established criteria and are in charge of managing PHC interventions.

### **2. Actions taken to revitalize PHC**

Community participation has been boosted by the adoption of the Bamako Initiative in 1988 and cost-recovery schemes. In 1990, the health system reform process initiated in the country resulted in the reorganization of the system into three interrelated levels: central, intermediate and peripheral. The number of health districts and health zones increased as a result from 46 and 633 to 64 and 911 respectively. A PHC Programme and a PHC Directorate were set up at the central level to guide PHC strategy implementation. The establishment of village health committees enhanced community participation in health. Criteria for the selection of village health workers, traditional healers and traditional birth attendants were established.

During the 1990-1999 period, a community health project supported by World Vision served as an example for expanding the PHC strategy in the country. This project involved community health workers (traditional healers, community mobilizers and vaccinators) who were chosen on the basis of agreed criteria. Community health workers included people who lived in the village,

provided services voluntarily (without remuneration), have at least primary school education, are married and have good moral qualities. The project provided short training courses on PHC components and means of transportation (bicycles) of workers within their catchments area and motorcycles to supervisors.

### **3. Challenges for PHC implementation and recommendations**

- (i) Lack of motivation of community health workers.
- (ii) Some health workers, especially physicians working in hospitals, are not involved in PHC activities and are not familiar with PHC concepts.

## **ETHIOPIA**

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

The general understanding of PHC is that it consists of preventive, promotive and essential curative service provided in the front line of the health care system by involving communities, stakeholders and other sectors. The Health-for-All target and PHC strategy were adopted in 1978. However, events on the ground indicate that the policy statement was not translated into action. The Ten-Year Perspective Plan (1984-94) emphasized PHC as its policy which promotes community participation, intersectoral collaboration, gradual integration of vertical programmes and specialized health facilities, and delivery of essential health care at affordable cost.

The health system was designed by introducing community health services in health posts at the bottom of the referral system, staffed by trained community health workers and traditional birth attendants. The national health policy issued by the current government (1993) also regards PHC as its core strategy. Its general directions and priorities reflect commitment to decentralization and democratization; focus on preventive and promotive health care and development of an equitable and acceptable standard of health services system to reach all segments of the population. The Twenty-Year Health Sector Development Strategic Plan (HSDP) under implementation is broken up into three-five year rolling plans, based on the national health policy. The plan focuses on comprehensive and integrated PHC with a major shift towards community-level services emphasizing preventive and promotive health care components without neglecting essential curative care.

The health sector management structure has also been reorganized in line with the overall government policy of decentralization. Accordingly, the ministry of health at the central level and regional health bureaux (RHBs) at the regional level are responsible for policy formulation and for developing guidelines. RHBs can adapt central policy into their regional reality. Policy implementation is mainly ensured by Woreda (district) health management teams and the Woreda administration.

## **2. Actions taken to revitalize PHC**

One of the recent innovations in the HSDP is the Health Extension Programme (HEP) which is believed to be the best mechanism for PHC implementation. HEP is designed to make essential health services available at community level and to each village administration (Kebele). It covers 16 packages delivered by two health extension workers (HEW). The HEW represents health as a member of the Kebele cabinet which consists of elected community members and representatives of education, agriculture and health.

The HEP would ensure equitable access to services because it reaches all of the 15,000 rural Kebeles. Because it is linked to a health centre it brings all essential health services including basic curative care as close as possible to the community. The health extension worker establishes contact between the community and the health system, bringing health care service to everyone, identifying patients and clients that need closer attention, referring cases timely and monitoring defaulters from various programmes.

The new health system, and particularly the HEP, is considered to be very promising and is supported by partners. So far, coverage of most preventive health programmes (EPI, antenatal care, family planning and environmental health) has improved tremendously in the regions where the HEP is introduced. The key factor in the success of this programme is political and high-level leadership commitment. Strong follow-up and monitoring of progress at a higher level had prompted the health sector and all partners to give due attention to this programme. As a result, nearly half of the 30,000 HEW needed by 2009 have been trained and work is in progress to achieve the target on time.

### **3. Challenges for PHC implementation and recommendations**

- (i) Ethiopia has more than 80 ethnic groups, languages and cultures. It is generally understood that essential services need to be delivered with community participation in ways acceptable and appropriate to this complex context.
- (ii) Although some promising developments were seen after the introduction of HEP, many challenges are faced in its implementation: availability of resources to support training, procure supplies and equipment, pay salaries and conduct regular supportive supervision. In addition, the 16 HEP packages are delivered free of charge. Since the aim is to achieve universal coverage of PHC, the financial implications of achieving this goal would be huge.
- (iii) The capacity of district health systems to support the programme are limited. There is also a need to integrate the HEP into the health system, create practical linkages with hospital services and ensure effective and regular support from the higher level of the system.
- (iv) One of the concerns is enhancing and sustaining community participation and ownership of this programme. This concern is mainly related to the absence of essential curative care at community level. The HEP is designed with no curative care while demand for such services from the community has continued to be a major concern documented by several reviews.
- (v) Harmonization and alignment with health sector reform agendas needs clarification. The need to strengthen and encourage private sector roles (particularly private-for-profit) in health service delivery and the profit orientation and focus of the sector on curative care pose challenges in HEP-private sector linkage.
- (vi) There is a need to redefine PHC and to develop generic guidelines for health policy monitoring and evaluation in the country within the context of the ongoing reform agenda.

## **GABON**

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

Since the Alma-Ata Declaration on PHC, the country has shown commitment to implement the primary health care strategy. During the 1978-1995 period, the following initiatives were undertaken to this effect: (a) administrative instructions on PHC (decisions, decrees and circular letters) were issued and disseminated; (b) national PHC services were created; (c) two zones were identified for coordination of activities (northern zone with five provinces and southern zone with four provinces); (d) management structures were established at national, provincial and divisional levels (national committee, development committee, health committee and health team); (e) extensive training in PHC was organized for trainers, dispensary nurses, village health workers, etc.; (f) 68 health units were constructed and drugs and basic supplies provided; (g) working tools were developed including technical guides, charts and technical reports; and (h) a special budget line was established to support community activities.

To make an assessment of progress in relation to these activities, three evaluations were conducted in 1989, 1991 and 1997 with the technical support of WHO. The evaluations revealed that progress was weak due to the lack of proper national health policy and a coherent PHC implementation plan compounded by the 1980-1990 economic crises and non-adherence to the Bamako Initiative. The available 1995 health policy document made no reference to PHC concepts or the role of communities and community health workers in the management of health at community level. These factors affected district operationality resulting in poor implementation of the PHC strategy. In addition, the available external technical assistance was not in line with PHC principles.

### **2. Actions taken to revitalize PHC**

In view of the gaps mentioned above, the government and its partners (WHO, UNICEF, CIDA of Canada, Italian NGO Alizee and Schweitzer Hospital Foundation) have embarked on the revitalization of the PHC strategy in the country through the following actions: (i) recruitment of a consultant with expertise in PHC; (ii) organization of a national PHC workshop which made specific recommendations for strengthening PHC implementation; (iii) establishment of a PHC support centre (CASSP) at the General Directorate of Health (DGS); (iv) selection of 15

divisions in each health zone to pilot the PHC implementation process; (v) formulation of the national health policy in 2004 encompassing the PHC vision.

### **3. Challenges for PHC implementation and recommendations**

- (i) In spite of the revitalization efforts mentioned above, the implementation of the PHC strategy is currently inadequate. Of all demonstration projects, only the one supported by Schweitzer Hospital Foundation is operational. The government and partners should therefore revisit the other pilot initiatives with a view to reviving them.
- (ii) There is a need for a mechanism for stimulating the commitment of the authorities, partners, health staff and communities in PHC implementation.
- (iii) Capacities of health personnel and communities should be built for effective management and implementation of PHC programmes.
- (iv) The health budget should be adjusted to include PHC implementation expenses.
- (v) There is a need to re-evaluate the PHC strategy to document the status of PHC programmes and draw up a PHC implementation plan.
- (vi) More resources should be mobilized to support the plan.

## **GAMBIA**

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

The PHC approach was adopted by The Gambia way back in 1979. Implementation started shortly afterwards. The Government declared its full commitment to Health-for-All by the Year 2000 and undertook the implementation of the PHC action plan (1980/81-1985/86) as the basis for health policy. The PHC concept was generally understood to be an instrument for improving access to health care services which were hitherto centralized in urban areas sidelining the majority of the population in rural areas. PHC is the cornerstone of the current national health policy and one of its objectives is to further expand health care so that no one is further than five km from a health facility.

Access to health care was significantly improved under PHC with the establishment of village health posts, outreach services and availability of community health workers (VHWs and TBAs). PHC was seen as an avenue for community participation in and ownership of health care delivery at local level as well as for ensuring greater sectoral involvement in health care delivery. PHC has been the driving force of the Gambian health policy and action plans. The first PHC action plan (1980-85) subsequently led to the development of national health policy documents and medium- and long-term action plans the main thrust of which focused on equitable distribution of health services through a three-tier health service delivery system: *primary* (village health service and community clinics), *secondary* (health centres) and *tertiary* (general hospitals and teaching hospital) complemented by a number of private and NGO health facilities.

PHC has been implemented in an integrated manner: most programme units at central level are using PHC structures and staff to carry out their activities. A multisectoral national steering committee was established during the initial stages of PHC implementation. PHC has contributed to increased community involvement which has been realized notably through the village development committees (VDCs) where they take part in management and major decision making in local health matters. This was later strengthened by the introduction of the Bamako Initiative (BI) in the 1990s. Intersectoral collaboration to some extent contributed to PHC advancement at community level through joint meetings and monitoring of health projects.

## **2. Actions taken to revitalize PHC**

The chronology of the PHC development demonstrates high political commitment by the government to PHC concepts. It included the following steps: the PHC action plan (1980-85), the first in the WHO African Region, developed with WHO support followed by national health development project (1987-92), health action plan (1998-2003) and the second national health policy and strategic plan (2007-2011). PHC implementation led to the development of the national health policy in 1994 (1996-2000) which was later updated and presented as the current health policy framework covering the period 2007-2020.

Health constitutes one of the largest components of the poverty reduction strategy programme. The BI has improved community participation in the management of health services. Due to the implementation of PHC and other policy directives in a politically peaceful environment, access to health services has improved and distribution of health facilities expanded to cover more rural areas contributing to equity in health delivery. Community-based interventions known as “Open Field Days” have proved to be a popular means of conveying appropriate health messages and

information, as well as enhancing community participation. The collection of information on community health by village health workers (VHWs) and traditional birth attendants (TBAs) using visual methods (e.g. pictures) contributed to the generation of data for health programmes.

Community skills have also been developed in the areas of VIP latrine construction and usage as well as the manufacture of improved local cooking stoves which reduced dependence on firewood. PHC became instrumental in the establishment of VDCs, which addresses village development holistically, including health development. The creation of regional health teams, and the establishment of technical advisory committees at the regional governors' offices and VDCs, has improved decentralization and community participation in planning and management of health care services at the district and community levels.

The current development priorities for the Government are education, agriculture and health. This is demonstrated by Government's allocation of 13% of the national budget to the health sector. A national health accounts has also been developed to facilitate the development of a national health financing policy. Multidisciplinary facilitation teams at all Governors' offices in the regions were created to foster partnerships among extension agents.

The Second Republic (1994 to date) saw a rapid expansion and transformation of health services with the construction of hospitals, health centres and village clinics. This has significantly improved accessibility and referrals within the system. Immunization services for children, mothers and pregnant women have been offered free of charge. In 2006, the Department of State for Health and Social Welfare (DSHSW) with partners launched the Emergency Maternal, Newborn and Child Health Project to reduce the high maternal and newborn morbidity and mortality rates. Subsequently, the Government made a pronouncement in 2007 that all pregnant women visiting government health facilities should be given free treatment.

A new incentive scheme has been developed and implemented for nurses and other health care workers. The in-service training unit was created to train/retrain VHWs and TBAs. PHC concepts have also been incorporated in the curricula of training institutions. A national essential drug policy was developed which advocates the integration of traditional medicine into the conventional health care delivery system. A national traditional medicine programme has been established at DSHSW. A functional Integrated Diseases Surveillance System was established to assist the government in monitoring the incidence of targeted diseases. The Government's current rural electrification project has improved access to electricity supply in major rural towns and growth centres improving the cold chain system for vaccines. The DSHSW, through the

support of WHO, has initiated a quarterly donor round table as a means of coordinating donor supported activities in the health sector.

### **3. Challenges for PHC implementation and recommendations**

- (i) Inadequate support to and lack of confidence in village health workers and traditional birth attendants.
- (ii) Misunderstanding of the PHC concepts and roles and responsibilities of different sectors or players in PHC implementation.
- (iii) Poor supervision and intersectoral coordination.
- (iv) Underutilization of previous positive experiences, e.g. the “Horse cart ambulance”, which was abandoned in the early 1990s for various reasons, was helpful in evacuating patients to nearby health facilities.
- (v) Poor control over funds generated from the sale of drugs.
- (vi) Inadequate communication between health centres and village health service.

## **GHANA**

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

Extending the coverage of quality basic and primary health care services to all Ghanaians has been reinforced as a major objective of the ministry of health (MoH) since the Alma-Ata Conference in 1978. In the late 1980s, a decision was made to minimize the vertical system and move towards integration and decentralization, hence comprehensive PHC which seeks to unite health with the total development of the community. Strategies were put in place to promote community participation, intersectoral collaboration, and use of appropriate technology as stipulated in PHC. The policy also stresses the development of horizontal institutional structures. Ghana adopted a system that accommodates both selective and comprehensive PHC strategies.

In 1978, Ghana piloted two projects in a rural setting on the principles of PHC (Danfa project) and Bamako Initiative (BI). The results from these projects enabled the health sector to review service delivery policies and strategies under its sector reform. Fiscal and managerial decentralization of health services followed thereafter. In 1996, as part of the reforms, the health

sector embarked upon the Sector Wide Approach (SWAp) and prepared a “Medium Term Health Strategy” out of which a five-year programme of work making PHC a policy cornerstone and a framework for health care delivery. The current national health policy “Creating wealth through health” is in consonance with the principles of PHC.

## **2. Actions taken to revitalize PHC**

Recently, Ghana adopted Community-based Health Planning and Services (CHPS) which is a set of strategies aimed at bringing health services to the communities. District health management teams throughout Ghana have been mandated to develop approaches to community health care that are consistent with local traditions, sustainable and include community participation and stewardship with an enhanced close-to-client (CTC) system. The CHPS strategy entails placing community health officers (CHO) who are nurses to live in the community with the people to whom they are to provide health care. The CHPS strategy has led to reorienting and relocating PHC from sub-district health centres to convenient community locations. Some 227 CHPS zones can now be found in all the 138 districts across the country.

It must be emphasized that the key component of CHPS is community-based service delivery that focuses on improved partnership with households and community leaders and social groups – addressing the demand side of service provision and recognizing the fact that households are the primary producers of health. As a policy, the health sector since 1997 has been allocating at least 42% of its resources to the district level and below. Another best practice in the implementation of PHC in Ghana is the introduction of national health insurance (NHI) in 2004 using District Wide Mutual Health Insurance Schemes (DWHIS) and exemption policies for equity in health. Members of the DWHIS are supposed to form a General Assembly to deliberate on the running of the schemes, thereby engendering community participation and ownership. The NHI is providing financial access through community involvement in health. The NHI is funded by 2.5% value added tax of goods and services, 2.5% monthly contribution from the salary of members of the pension fund and a minimum annual premium of 7.2 Ghana cedi (US\$ 8) covering most services provided at a district hospital level.

### 3. Challenges for PHC implementation and recommendations

- (i) The misinterpretation of the PHC concept that perceives PHC as a second rate health care for the poor is a major obstacle in the implementation of the strategy.
- (ii) The preference of selective PHC to comprehensive PHC initially due to reasons including lack of resources is hindering the implementation of the comprehensive PHC.
- (iii) Lack of political will and leadership to implement PHC is a major challenge. This is reflected in resource allocation to the sector. In Ghana, district assemblies are allocated 7.5% of total national revenue under District Assemblies Common Fund (DACF) for socio-economic development. Resource allocation to health activities under DACF suffers since the perception that health is a critical input or outcome of economic development is not strong.
- (iv) Another obstacle is weak intersectoral action. This is particularly so when health is seen to be the sole responsibility of ministry of health (MOH). There are no policies, guidelines and effective mechanisms in place for the health sector to work with other government departments and agencies. Some work has been done in this direction, but needs to be improved and guided.
- (v) Inequitable distribution of human resources and their shortage is another obstacle to PHC implementation. The two most urban regions in Ghana share among them 75.2% of all medical doctors with the three most deprived rural regions having only 3.8%. The trend is similar for other cadres of health professionals.
- (vi) The health sector, just like other sectors, is under the centralized planning and management system despite the introduction of decentralization since 1989. Ghana Health Service was created mainly as a service delivery arm of the MoH to foster devolution of authority, yet decisions regarding infrastructure development are highly centralized thereby limiting the ability of local constituents to take such decisions.
- (vii) Deepening poverty and slow socioeconomic development are constraining factor for PHC implementation. Even where positive economic growth rates were registered, they are not high enough or sustainable. Improved macroeconomic management, through prudent monetary and fiscal policies, is necessary to provide the resources needed for economic development including implementation of PHC.
- (viii) Planning, implementing, monitoring and evaluating PHC needs a good information base. However, weak health information systems and poor databases have constrained

PHC. Several attempts have been made to rectify this anomaly, including establishing postgraduate courses in health information at two universities in Ghana.

- (ix) The high level of pollution, poor food safety, lack of safe water supply and sanitation constrain the implementation of PHC. The widespread use of health promotion, community participation and intersectoral collaboration are some of the strategies being used to address these constraints. The need for heavy investment in water and sanitation has been advocated for. The unavailability of local resources and the inability to mobilize external resources to undertake and maintain such ventures is slowing the implementation of PHC.

## **GUINEA**

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

The country adopted the “Health-for-All by the Year 2000” strategy in 1977 followed by the Alma-Ata Declaration on Primary Health Care in. During the national conference in 1984, the ministry of health (MoH) reaffirmed its commitment to PHC with the following principles: harmonization of the three types of health care- curative, preventive and promotive; individual, family and community health; community participation in health programme planning, management and implementation including health financing and cost-recovery schemes; intrasectoral and intersectoral collaboration to be promoted by the various departments of the ministry of health, with the State Secretariat on Decentralization, Ministry of Planning and Ministry of Finance. It was proposed to adjust the strategy to the national and regional realities.

Three major strategies were adopted to achieve PHC objectives: improve effectiveness of service delivery; reduce service costs and ensure the sustainability of the service. In 1986, the situation analysis undertaken by MoH revealed several shortcomings in health services, including lack of medicines and consumables at health facilities, dilapidated infrastructure and run-down medical equipment, lack of logistical support to personnel resulting in their demotivation, loss of confidence of the population in health services, poor immunization coverage and excessive use of a costly outreach strategy. To reinforce health services and involve communities in health matters, there was an urgent need to revisit the PHC strategy which was embodied in the Bamako Initiative adopted by MoH in 1988, and in the national health development plan. Because of the number of interventions, the current health strategy has been aligned with the

PHC principles which imply better service coverage, greater community participation in planning and financing local health programmes through health and management committees, introduction of cost-recovery schemes, etc.

## **2. Actions taken to revitalize PHC**

A hospital reform took place in 1990 resulting in improvements in the referral system and an increase in the number of referral hospitals (from 8 in 1988 to 33 in 2006 comprising 26 district and 7 regional hospitals) and community medical centres (5 in Conakry, 2 in rural areas). In 1994, a workshop was organized to formulate a national health policy to address new challenges facing the health system. In 1997, a National Health Forum was organized to select priority programmes for the period 1997-2010, and initiate the process of formulation of the national health plan. An important workshop was held in 2001 to validate the 1997-2010 national health plan.

These initiatives led to the development of a health system based on PHC strategies: expansion of health infrastructure which resulted in an increase in the number of health centres from 98 in 1988 to 401 in 2006; immunization coverage for the same period reached 68% in 2006, from 5% in 1988. Similarly, positive changes were noted in the proportion of pregnant women having prenatal consultations (54% in 2006) and in other health indicators. The putting in place of depots for essential and other drugs boosted their availability throughout the 1988-2000. The human resources development strategic plan was formulated on the basis of the national health development plan to ensure a fair distribution of health personnel, continuing staff training and formative supervision to improve staff skills. Community participation in health programme implementation and management also improved. Cost-recovery schemes were instituted. Other developments include the strengthening of the health information system, improved collaboration between various programmes within the health sector, and increased private sector involvement in health provision (private pharmacies, medico-surgical clinics, etc.).

## **3. Challenges for PHC implementation and recommendations**

- (i) The decentralization of health services focused more on health infrastructure than on health care programmes. The management of these programmes is still centralized, with little decision-making power at local level.
- (ii) Despite some improvements mentioned above, there are still shortages in human, material and financial resources at local level. There are still problems in the

recruitment and geographical distribution of health personnel as well as scarcity of specialized staff. There is therefore a need to urgently streamline the national human resources for health plan.

- (iii) There are some unresolved issues regarding community participation in health matters: the role and composition of local management committees are defined by the administration rather than by the communities themselves. The absence of regulatory instruments on local NGOs and associations supporting community health is another challenge.
- (iv) There are still weaknesses in the provision of essential drugs which some times are out of stock. The cost-recovery mechanism is not well clarified and understood. Some drugs sold by private pharmacies are not accessible to the population due to their high cost. The central drugstore should be supported and reinforced to play its coordinating role as a principal actor in the procurement and distribution of essential drugs. Possible support from external sources such as the Global Health Fund, Global Alliance for Vaccines and Immunization, AIDS funds, etc. should be explored.
- (v) The health information system does not include some public health data and the results of private sector activities.
- (vi) There is a need to formulate a national health financial policy with the participation of other sectors. It is also necessary to finalize the national health accounts.
- (vii) There is a need to pursue intersectoral collaboration involving health-related sectors, NGOs and associations.

## **GUINEA BISSAU**

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

The country adopted the Three-phase Health Development Scenario followed by the Bamako Initiative (1987). In 1997, a national health development plan (1998-2002) was developed to promote a health policy which implies equity, financial accessibility, efficacy, community participation and intersectoral collaboration. The policy advocated the development of a coherent health system to manage health services in a country with poor human, material and financial resources and health services that depend mainly on external support. The plan provided

orientations for the development of a four-tier primary health care system with basic health units at the peripheral level which is the first level of contact. The community provides primary health care and trains community health workers. These units are supported by various types of health centres (A,B,C) which provide services to populations within a five to ten km radius and those living in communities with limited access to health care services.

This PHC system ensures equity in health and encourages the participation of communities in their own health matters through community health workers. It also promotes integration of health programmes through the implementation of the minimum health package designed for each of the above-mentioned health centres which function in a complementary manner.

## **2. Actions taken to revitalize PHC**

The national health plan and health policy were reviewed in 2002 by the government and its key partners in order to revitalize PHC implementation. As a result, a new 2003-2007 plan was developed followed by the 2008-2012 plan which is currently being formulated focusing on the reinforcement of health services management and improved coordination of activities by all stakeholders and partners. This plan is reviewing the content of the minimum health package to make it more relevant to local health realities. It also aims to enhance the implementation of the Bamako Initiative through improved financial management and community participation.

The main achievements of PHC implementation include: (a) overall accessibility of the population to quality health care; (b) improved and transparent management of financial and material resources and their equitable distribution which has helped to strengthen the institutional capacities of all levels of the health system; (c) improved quality, effectiveness and distribution of human resources as a result of the introduction of training in management; (d) improved health promotion through IEC and intersectoral collaboration; (e) enhanced integration of health services through micro-planning and provision of a minimum health package with various types of care to the population delivered by fixed and outreach services (e.g. immunization, ITN, IMCI, HIV/AIDS, IEC, etc.).

### **3. Challenges for PHC implementation and recommendations**

- (i) Fragility of health services due to insufficient financial resources: the proportion of the actual health budget in the overall government budget is around 4% as opposed to 15% suggested by the Abuja Declaration. The budget is determined by the availability of funds and not by needs. It is obvious that more resources are needed for the attainment of MDG health-related targets.
- (ii) There is a need for greater transparency in the utilization of financial resources generated through the Bamako Initiative.
- (iii) Frequent stock outs of essential drugs at health facility level is another challenge.
- (iv) Lack of training of health management committee members in issues regarding community health management and their involvement in planning and evaluation of health activities and programmes.
- (v) Reduced external funding in health by key partners following the 1998 events in the political life of the country. There are also difficulties in the management of available external funds due to complicated management and reporting procedures.
- (vi) Lack of health resources, especially of qualified health personnel, which is an obstacle to the provision of good quality services to the population. There is also lack of logistical support and organizational skills in health delivery activities such as outreach visits.

## **EQUATORIAL GUINEA**

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

The PHC strategy was introduced in the country in 1983 and was adopted by the Government in 1986. It has been considered as highly appropriate to the country's situation and as a national strategy in general and health policy and programme in particular. It has therefore been fully integrated into the national health policy and strategic documents as a cornerstone of health development.

PHC implementation is based on equity which has expanded accessibility to health care. Suffice to note that after the introduction of PHC principles, health service coverage rose to more than 70% in rural areas. From the outset, PHC implementation has been carried out in an integrated manner through the community and district health and development committees. According to a presidential decree, the members of these committees are selected from various sectors: health, education, agriculture, women's organizations, etc.

## **2. Actions taken to revitalize PHC**

Community participation has been an essential factor in PHC strategy implementation. The following activities are carried out with community participation: local situation analysis, identification of drinking water sources, locating community health structures, schools and churches, mapping of communication routes (roads and bridges), etc. Communities are also directly involved in local health management, as well as in selecting community members who serve as community health workers, midwives, traditional birth attendants and traditional health practitioners.

During PHC implementation, special efforts are made to educate communities on disease prevention, recognition and control (IEC). As a result of these interventions, health coverage has improved (>70%) and there are positive changes in some important health indicators: the infant mortality rate has declined considerably to 93/1000 live births; life expectancy at birth is 53 years; since 2004 immunization coverage has exceeded 85%; etc..

## **3. Challenges for PHC implementation and recommendations**

- (i) In the 1980s and 1990s, PHC implementation at community level was supported financially by bilateral cooperation partners (e.g Spain). After the suspension of such support in 1993, the scope of PHC activities and projects has been reduced.
- (ii) In the structure of the ministry of health, there is no provision of a national officer to be in charge of the PHC programme.
- (iii) The majority of district health teams are not operational due to various reasons (e.g. lack of transport, shortage of staff, etc.).
- (iv) The awareness of health personnel working at various levels of the importance of the PHC strategy is low.
- (v) At the operational level, there is no budgetary line for implementing PHC activities.

- (vi) Very often, community health workers abandon their posts due to low motivation and lack of supervision. Motivation is also lacking among members of health teams and health development committees.

## **KENYA**

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

From the mid-1970s, the country's economic growth started to decline, due to internal and external factors. Prior to the Alma-Ata Conference in 1978, the health sector was already feeling the strain of maintaining the level of investment needed to keep its health services running. The PHC approach was therefore introduced at an opportune moment for the country to refocus its health strategy

After the conference, selective PHC was implemented with introduction of vertical programmes and projects which, however, were fragmented and uncoordinated. In 1993, the government of Kenya initiated a major economic reform and liberalization programme supported by the World Bank and the International Monetary Fund. This reform process was extended to cover the health sector in 1994 with the formulation of a new health sector policy reflected in the Kenya Health Policy Framework (KHPF, 1994-2010).

For the first time also, a framework for health sector reform was established and the national health policy was presented in a comprehensive manner in a single document embodying the PHC approach. This approach addressed the wider issues of equity, social justice and democracy which were previously ignored in the process of health policy development. It also espoused such principles as community and private sector participation, and decentralization.

The PHC concept has been understood at different times in different ways in Kenya. At present, the strong focus is away from looking at PHC as a project, but rather as an approach to guide service delivery. This is a key conceptual change and focus.

## 2. Actions taken to revitalize PHC

In 1999, the ministry of health (MoH) produced the first national health sector strategic plan, (NHSSP I), 1999-2004 to provide a framework for implementation of the KHPF through: (i) strengthening governance; (ii) improving resource allocation; (iii) decentralizing health services and management; (iv) shifting resources from curative to preventive and PHC services; (v) granting autonomy to provincial and national hospitals; and (vi) enhancing collaboration with stakeholders under a SWAp arrangement. However, implementation of the NHSSP I, based on the PHC approach, did not lead to the expected turn around. Services continued to be provided in a vertical manner, with consolidation of the programmatic approach in the sector. As a result, health outcome stagnated or worsened, poverty levels went up from 47% in 1999 to 56% in 2002.

To reverse the downward trends in health indicators, the NHSSP II, 2005-2010 was formulated in line with the PHC approach advocating principles such as: increase equitable access to health services; improve quality, efficiency and effectiveness of service delivery; enhance the regulatory capacity of MoH; foster partnerships in health; and improve financing of the health sector. To better guide the implementation of the NHSSP II, in line with the PHC approach, the sector decided to strengthen the implementation framework, which was lacking in the NHSSP I. As such, a cross-sectoral Joint Programme of Work and Funding (JPWF) was formulated to guide the investment decisions of the government and health sector partners so as to address equity with special focus on the community level, strengthen human resources health system, enhance efficiency and budget effectiveness, and strengthen sector stewardship and partnerships with all stakeholders by ensuring clarity of roles and responsibilities and instituting joint planning, funding and monitoring arrangements (SWAp).

At present, there are clear frameworks guiding interventions in all the PHC thematic areas. The health system delivery structure is now designed around the basic PHC framework: the **community level** is the level where interventions are provided by community health workers and coordinated by community health extension workers; the **rural health centres represent levels 2 and 3** of the health system which form the backbone of health care delivery; **and referral services represented by levels 4, 5 and 6** of the system (district, provincial and national levels respectively).

The following initiatives were also undertaken to reinforce NHSSP II implementation: the preparation of the country's first Joint Programme of Work which serves as the guide to all investments in the sector; implementation of a bottom up, demand-driven annual operational planning process; initiation of a performance monitoring mechanism to enhance accountability and follow-up; formulation of a comprehensive community approach by the sector; revision of the basic package approach which is based on encouraging different intervention areas to define sets of services they will provide. Services are planned, monitored and reported by life cycle cohort, as opposed to programmes. Vertical programme planning, implementation and reporting is restricted to the six core functions of the central level, thus limiting their involvement in the implementation process.

The present approach to service delivery has taken the country back to the basic principles of the PHC approach. The key difference is that a clear implementation and monitoring framework has been put in place to ensure regular follow-up and corrective action during the implementation process. The Kenya Essential Package for Health (KEPH) was introduced; it focuses on services that maintain the health of communities, as opposed to services that fight illness. The sector therefore places greater emphasis on programme activities relating to health promotion and prevention. Another innovation is the introduction of a life cycle cohort approach to service delivery. Services are to be provided for six defined life cycle cohorts: (i) pregnancy and the newborn; (ii) early childhood; (iii) late childhood; (iv) adolescents; (v) adults (and services for all life cohorts); and (vi) the elderly. Planning and monitoring for service delivery is based on results to be achieved across different life cycle cohorts, and not on programmes. This again enables a clear focus on the level of health being generated across different cohorts. Interventions are therefore not focused on maintaining the life of programmes, but of cohorts.

### **3. Challenges for PHC implementation and recommendations**

- (i) While policy has been more in favour of a comprehensive PHC approach, services continue to be highly focused on curative care at higher levels of the health system.
- (ii) Like in many other countries, selective implementation of the PHC approach has led to a proliferation of vertical programmes in the country, each operating independently of the other.
- (iii) Some key areas, such as supervision, are still weak and disintegrated. The process of establishing an integrated supervision approach is still ongoing. The need to clarify roles of technical programmes in this process has to be properly addressed.

## LESOTHO

### 1. The PHC concepts: their understanding and appropriateness to the national context and health policies

Lesotho adopted PHC as a strategy for providing health services in 1979. From its adoption, the PHC strategy has been viewed as a vehicle for the attainment of the highest level of health for the people. The national health and social welfare policy is based on PHC principles which include: **political commitment**; community participation; **accessibility, availability** and **affordability** (fee structures take into consideration the ability of people to pay); **intersectoral collaboration**; **disease prevention**; **health promotion** through behavioural change; and **equity**.

In accordance with the Constitution and health and social policy of Lesotho, all people shall have equal access to basic health care and social services (within eight km from the nearest health facility). According to the policy, communities shall not be mere consumers of services but shall actively participate in decision-making and planning for health and social services as well as in implementation of programmes. The policy encourages an **integrated** and holistic approach to health service delivery by integrating the treatment of diseases with aspects of nutrition, hygiene and promotion of healthy lifestyles. The primary focus of the PHC strategy has been to decentralize health care delivery down to the community level. The success of the health delivery system has been greatly influenced by the level of community participation in the implementation of public health interventions: water/sanitation projects, nutrition services, immunization services, etc. The five-year development plan 1991/92 – 1995/96 identified health as one of the social services that promotes public participation in the formulation and implementation of development programmes.

Under the PHC system, there are four levels of health care delivery, namely: *community; health centre; hospital/district; and central*. Health services are provided mainly by the government and the Christian Health Association of Lesotho. In recent years, private sector participation has grown tremendously.

## **2. Actions taken to revitalize PHC**

The government recognizes the need to restructure health services and to accelerate the national health development process in pursuance of HFA goals. In order to make PHC services more accessible to the people, 18 health service areas (HSA) were established for 10 district administrative areas. They are served by a hospital acting as a reference facility and a number of health centres. The PHC approach promoted the comprehensive delivery of health services through the supermarket approach. An Essential Services Package concept was introduced to ensure the integrated provision of interventions. The District Health Package and Essential Service Package have been defined for the different levels of the health care delivery system covering essential public health interventions, communicable disease control, sexual and reproductive health, essential clinical services, health education, immunization, nutrition and growth monitoring, environmental health and sanitation.

The necessary resources for implementing the packages have been defined. The District Management Improvement (DMI) Project was initiated to improve the management capacity of the Ministry of Health and Social Welfare (MoHSW) resulting in the development and dissemination of a set of tools contained in the HSA Management Manual. Activities at community level are provided through community health workers, local latrine builders and extension workers such as health assistants with support from health centre nurses, public health nurses and public health inspectors. Their contribution includes detection of disease outbreaks, provision of health education, nutrition surveillance, securing sites for outreach services, construction of latrines and buildings for use as village health posts, etc. The communities are also involved in the management of health facilities and other structures through health centre committees, village health committees or village water committees.

PHC activities are facilitated by a fairly sound transportation system. A national communication network (2-way radio system) has been operational among health facilities and referral layers including the national network system coordination office. A good system for maintaining the cold chain for EPI backed by a maintenance arrangements is in place. For all cadres of staff, comprehensive job descriptions have been developed. The human resources development strategic plan 2005-2025 has been developed (including continuing education). A Health Service Area (HSA) Training Committee was established for the planning and coordination of training in the health service area (HSA). Approximately 6 000 community health workers were trained.

An essential medicines list, standard treatment guidelines and the national drug policy are in place and have recently been reviewed. A system for procurement of medicines exists. All medicines are procured through the National Drug Service Organization which is mandated by the MoHSW to procure, store and distribute medicines. All health personnel in the public sector working in difficult areas receive a monthly hardship allowance. A comprehensive incentive package has been developed for health workers but is yet to be implemented. Institutional housing is also provided to health workers subject to availability. Budgetary allocations to the health sector continue to increase over the years.

### **3. Challenges for PHC implementation and recommendations**

- (i) Over-centralized decision making and management of health services discourages community commitment and participation.
- (ii) An inaccurate and incomplete health information system hampers evidence-based decision making.
- (iii) Health centres fall within district boundaries or a defined demarcation area of HSA. This often poses a challenge with regard to population denominators since the national population is based on district boundaries as opposed to HSA boundaries.
- (iv) The shortage of personnel is the biggest challenge facing district health centres: patients often seek services in hospitals thus bypassing them. Inefficient human resource management also contributes to the discontent and high attrition rate in the sector.
- (v) There is insufficient communication within the referral chain which affects its coordinated functioning.
- (vi) Shortages in support services such as transportation prevent district and health centre teams from reaching communities to follow up and supervise activities.
- (vii) Incentives for community health workers are generally too meager to maintain their continued involvement in PHC activities.
- (viii) Weak monitoring by the different levels of the system resulted in the collapse of some ongoing health projects.
- (ix) Health care facilities are not optimally utilized and well-maintained.
- (x) Pharmaceutical supplies are not used rationally due to lack of explicit policy guidelines and an efficient management system.

## **LIBERIA**

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

PHC as a framework for national health care delivery was introduced in the country in the 1970s and its principles were integrated into the national development plans during the 1981-1995 period. By the early 1990s, PHC programmes were operational in 5 of the 15 counties, providing a wide range of decentralized health care through 80 health posts (HPs) and 25 health centres (HCs).

During the Liberian civil war, PHC infrastructure was destroyed, personnel were killed or migrated to safety and external support was halted. With the stabilized national situation, the new government has initiated national recovery programmes. The rebuilding of social services and infrastructure is prioritized in the country's poverty reduction strategy. The national health policy has PHC as its foundation for a health system based on promotive, preventive and curative care. The national health development plan seeks to improve health care through expanded access to basic health care, backed by referral services and resources. It focuses on community participation, availability of material and financial resources, strengthening of managerial capacities of staff, improvement of quality and coverage of health interventions and strengthening of partnerships.

As was evident from the recent PHC assessment, for service providers, PHC is a multi-dimensional health concept that focuses on the basic and essential health needs of the people and which implies the accessibility, affordability and availability of health care for the people with their participation. Decentralization of PHC delivery is a critical factor in the implementation of PHC. Primary health care delivery in Liberia emphasizes community participation to improve programming and effective implementation. Health is seen as a crucial component in restoring infrastructure and basic services which are a pillar of the country's poverty reduction strategy paper. The government has declared that PHC shall be an integral part both of the national health system, of which it is the central function and main focus, and of the overall socioeconomic development of the community.

## **2. Actions taken to revitalize PHC**

Currently, the major thrust of the government's health reconstruction programme is the revitalization and expansion of PHC through a "phase approach" strategy and the Basic Package of Health Services (BPHS). With the assistance of various partners, the government, in 2006 and 2007, revised the national health policy and formulated a national health development plan. The revised national health policy emphasizes PHC as the foundation for the provision and attainment of improved health for the majority of the population. The policy stresses that PHC will place citizens on an equal partnership with health professionals in decision-making about health. It indicates that PHC shall focus on the community, district and county as the locus for decision making in relation to resource management and service delivery. The policy furthermore emphasizes the need for expanding access to PHC by investments in priority interventions, human resource, support systems and infrastructure, as this will establish the building blocks of an equitable, effective, responsive and sustainable decentralized health care delivery system.

The national health development plan outlines the major PHC objectives and resources to restore effective high quality services, and to make them accessible to the majority of the population. The Basic Package of Health Services has been instituted to address the post-war challenges of improved access to PHC services. The PHC approach for the package is expected to be adopted for each level of the health system: community, clinic, health centre, district hospital and tertiary hospital. It is anticipated that an integrated approach solidly based on the PHC strategy will be used to deliver the package. Recent efforts by government and partners have witnessed the emergence of community participation and involvement in the development of PHC, especially the development of the national health plan, and county and district health plans.

Currently, Liberia's health sector is in transition from emergency to development, as a large percentage of the population-especially the rural and urban poor- still have limited access to health and other social services. The current government key health priorities include: building human resource capacities; ensuring a financially sustainable PHC system; re-establishing an efficient referral system; strengthening health management and information systems, strengthening support systems; etc. In January 2008, an assessment was conducted by MoHSW and NARDA in five counties (G. Gedeh Nimba, Bong, Bomi, and Cape Mount) with the MoHSW and WHO teams to document best practices in PHC delivery. The methods used were interviews and focus group discussions involving health staff, community members and community-based development partners. The findings include the following: (a) Sources of

information about PHC are diverse. They include community health education meetings, social mobilization and sensitization events in the hospitals, clinics and schools; (b) The government has restructured county health facilities, including the setting up of management teams and provision of the basic health package; (c) Government's role in supporting PHC has increased through salary payment and other financial contributions to the county health team and the hospitals. Subsidies to private/faith-based health institutions have also increased; (d) At the community level, the concept of household health promoters as a response to improve individual participation in PHC was also advanced. In Nimba County, communities donated land and facilities and made contributions to purchase an ambulance; (e) Trained traditional healers/herbalists and CHWs play a significant role in the delivery of PHC and in the reduction of the maternal mortality rate; (f) There is an increase in the utilization of health services linked mainly to community awareness and health education programmes, etc.

### **3. Challenges for PHC implementation and recommendations**

- (i) Rehabilitating health facilities with specific focus on under-served areas. The 14 years of war devastated the country, including the health sector. Government's effort in translating health policy commitment into action is being constrained by limited resource capacity.
- (ii) Equitable redistribution/redeployment of health workers to under-served areas and upgrading their skills.
- (iii) Expanding access to an acceptable quality of basic package of health care including essential medicines. The quality of health services is still a major problem specifically in rural areas (lack of quality health workers, inadequate logistics, poor working conditions, illegal circulation of substandard drugs, lack of basic hospital equipment, etc.).
- (iv) Improving management and supervision at service delivery points.
- (v) Decentralization and capacity building of support services.
- (vi) Limited viable community structures to deal with the wider issues of PHC. In some communities, the VDCs are operational, but they are based on specific projects rather than on a sector. There is a need to engage the community actively in rebuilding the health system.

## MADAGASCAR

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

Since the Alma-Ata Declaration in 1978, PHC has been considered as an essential element of health policy intended to ensure equity in the provision of health services. The health policy takes into consideration recent developments in the health and demographic profile of the population and socioeconomic conditions in the country.

A decentralization strategy has been adopted to bring integrated services closer to the population and to increase health coverage and accessibility. Thanks to these new approaches, improvements in a number of essential services and programmes and in their sustainability are documented: immunization, maternal and child services, provision of drinking water and sanitation, provision of essential drugs, among others. Notable improvements are also recorded in community participation and intersectoral collaboration in health.

There are three clearly defined health structures at central, regional and district levels complemented by the community level. The latter has health and nutrition community workers who provide health and nutrition information to the population and participate in other community-based interventions. The district level, comprising basic health centres and a first-level referral hospital, provides the Complementary Activity Package (basic health care package) and serves as the main interface with communities. Apart from government and partner financing, the health system is supported by cost-recovery funds generated by direct payments for health care by households and sale of drugs. A portion of the last component (2.2%) is paid into the “Equity Fund” to support the health needs of underprivileged people.

## **2. Actions taken to revitalize PHC**

There is a clear manifestation of political commitment to PHC at the highest level. PHC principles are embodied in the national health policy, as well as strategies for the strengthening of the district health systems. The Madagascar Action Plan (MAP) has been developed to implement the health policy and to meet MDG health-related targets. The main underlying theme of the MAP is to promote decentralization and shift decision making powers to the regional and community levels. Health services have been expanded and about 65% of the population have access (within five km) to health facilities.

The training of health personnel has been intensified, resulting in the improvement of the health personnel/population ratio (1.7/10000- physicians; 0.75-0.80/5000- nurses and midwives). Health facilities in hard-to-reach zones are being strengthened. A safety net for poor people has been put in place through the establishment of an equity fund. Purchases of drugs, laboratory supplies and consumables are centralized (through SALAMA). Sustainability in the provision of essential drugs is achieved by direct payments by households for health services and medicines.

The country enjoys excellent collaboration with partners: substantial contributions to the health budget are made by bilateral cooperation (36%) and there is also a network of external and local NGOs supporting the health sector. Some important health indicators have improved (maternal mortality ratio of 469/100 000 live births; infant mortality rate of 94/oo, in 2004 and <5 mortality- 58/oo in 2005). Policy documents and strategic plans have been developed for priority health programmes (EPI, Reproductive Health including Family Planning, IMCI, Nutrition, HIV/AIDS, STD, Non-communicable diseases, Health Promotion, Environmental Health, etc.).

## **3. Challenges for PHC implementation and recommendations**

- (i) Improve the institutional framework of the health system to ensure smooth implementation of national health policies and sectoral plans in order to achieve the health-related millennium development goals. It is very important to facilitate realistic planning/programming and evaluation of achievements, collection and analysis of reliable data as well as harmonization of indicators.
- (ii) Although the decentralization policy is well articulated in policy documents, its implementation is weak. Health manpower has instead been “deconcentrated”. There is a need to devolve the management of the local health system and decision-making power to regional and community structures.

- (iii) The integration of vertical programmes at grassroots level is rather weak. There is a need to harmonize activities and delivery strategies of various programmes and select priority actions for integration. In addition, mechanisms for motivation of community workers should be introduced.
- (iv) There are considerable regional disparities concerning the availability of health personnel. The rural regions are somewhat deprived in this regard. Therefore, the recent advances in human resource development should be accompanied by fair distribution of health personnel among regions. There is a need to equip the referral hospitals with qualified health personnel and address shortages of administrative personnel at all levels.
- (v) The private sector is not sufficiently integrated into the health system.
- (vi) The level of utilization of health services by the population in general is low-about 50%. This indicator is affected by poor access to health services by populations living in inaccessible or hard-to-reach areas. This constitutes a huge obstacle for PHC implementation. To address this challenge, there is a need for concerted efforts by the MoH, health managers, partners as well as communities.
- (vii) The efforts of the government to address equity in health provision are commendable. However, the coverage of people benefiting from the Equity Fund or health insurance is rather low (1% and 5-20% respectively). Accelerated action is needed to improve these levels as an important measure to achieve MDG and poverty reduction targets.

## **MALAWI**

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

In the Malawi context, PHC is defined as essential promotive, preventive and curative health care made available to all individuals and families in the community by means acceptable to them, through their full participation and at the cost that the community and the country can afford, and encouraging their development in a spirit of self-reliance and self-determination. This definition indicates that the fundamental policies of PHC and Health-for-All are based on concerted action in the health and socioeconomic sectors following principles of the Alma-Ata Declaration. The focus for PHC in the country is the improvement of the quality of life and maximum health benefits to the greatest number of people, especially those who are less privileged.

The health and PHC policies emphasize the need for greater responsibility for health by individuals and communities and their active participation in attending it. The PHC has been adopted and integrated into health and other relevant programmes as an underpinning strategy into the current national health plan. There is high appreciation by the communities for their participation in PHC implementation as most individuals and communities do realize that they need to take responsibility for their own health.

Due to adverse economic conditions during the last few decades, budgetary allocation for health declined over the period. Mortality rates remain high while life expectancy has declined. In this context, the PHC objectives focusing on improvement of quality of life and maximization of health benefits to all people are highly relevant.

### **2. Actions taken to revitalize PHC**

A series of technical and administrative consultations and working sessions were undertaken for operationalizing PHC and streamlining its implementation. The health system structure from national to district and area level was formulated and a cadre of community level PHC workers selected by and responsible to their own communities was established. PHC operating principles of community participation and multisectoral and intersectoral collaboration were adopted. Commitment of the Government and stakeholders to PHC principles, including pledges to increase resource allocations for its implementation was secured and included in the health

policy reform package. The essential health package was introduced as an avenue to reach equity in health care delivery. The sector-wide approach (SWAp) was also adopted to serve as an engine for the advancement of the package. There have been positive developments in allocation of financial resources to the health sector despite the economic hardships. The Ministry of Health and Population has made commendable efforts by increasing allocations to districts and community-based activities shifting resources from ministry headquarters, central hospitals and regional offices to the district level. In 2003, a study was commissioned by WHO to review experiences in PHC implementation which documented the achievements and identified challenges facing the programme.

### **3. Challenges for PHC implementation and recommendations**

- (i) The planning, development and deployment of human resources and utilization of PHC workers is a major challenge: staff shortages, recruitment in favour of tertiary health care, often urban-based, insufficient output from training institutions call for an urgent redressing of the human resource situation.
- (ii) There is a lack of water supply and sanitation and proper hygiene practices are rare in most of communities resulting in poor access to water and sanitation. The incidence of diarrhoea is high and cholera outbreaks are common.
- (iii) Private sector and internal resource mobilization to support PHC activities should be intensified along with prudent financial management and budgetary rationalization.
- (iv) To ensure increased availability and accessibility of essential drugs, nationwide Village Clinics need to be established as opposed to a pilot strategy which has limited impact.
- (v) Households and communities are not adequately empowered to identify their health problems and participate in implementation of initiatives to solve them. Most communities and health units are only involved in activities that are not broad-based to tackle root causes of ill-health.
- (vi) Health education and communication services have been successful in addressing most health concerns (HIV/AIDS, family planning, nutrition, immunization and other interventions). However, practice and the behaviour of people on the ground do not reflect such successes. There is a need to review and evaluate the effectiveness of the health communication strategies for greater impact on behavioural change among the target audience.

- (vii) There is a need to intensify the prevention and control of endemic and other diseases using available health technologies and PHC strategies such as immunization (childhood diseases), insecticide impregnated bednet (malaria), ORS (diarrhoeal diseases), home-based care packages (HIV/AIDS), IMCI tools (ARI and pneumonia), etc. which are the major causes of child and adult mortality in the country.

## **MALI**

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

The country adopted the Alma-Ata Declaration and initiated primary health care programmes based on the establishment of village health committees and targeted training of hygienists and traditional birth attendants (TBAs) who are equipped with TBA kits. A sectoral health and population policy declaration was adopted by the Health Policy Assembly to improve the health of the population through enhanced access to health services and sustained health service coverage. With government and partner support, community health associations and community health centres were set up. Each centre serves 5000 people within a radius of 5-10 km. A minimum package of activities (MPA) was defined for the centres with priority health care interventions.

The current health policy objectives include extension of health service coverage in hard-to-reach and poor areas by constructing and rehabilitating health centres, involving the private sector in health matters and using alternative strategies such as holding outreach and mobile clinics, promoting family health practices, among others. The policy adopted a multidisciplinary approach with decentralization as an operational strategy to ensure equity in health for all people in the country including those living in rural areas. The health policy also encourages the participation of people in improving their own health through community-based committees and associations which take part in planning, monitoring and evaluation of health programmes and activities.

## **2. Actions taken to revitalize PHC**

To revitalize the PHC approach in the country and boost community participation, community health centres, and community health associations and federations were established at community, local, regional and national levels (ASACO, FELASCOM, FERASCOM and FENASCOM respectively). The implementation of PHC activities and strengthening of its strategies by the government and its health partners through improved health financing and management have contributed to the improvement of health service coverage and, consequently, the health status of the population.

Compared with 2001, rapid improvements were observed in 2006 in essential health indicators as well as in the area of human and material resources and infrastructure development. These include the construction of community health centres which increased from 557 in 2001 to 785 in 2006; increased population coverage (within <15km) by the minimum package of activities, from 66% to 76%; increased proportion of pregnant women having prenatal consultations, from 52% to 75%; increased proportion of deliveries attended by trained health personnel, from 41% to 55%; enhanced immunization coverage rates (measured by DPT3 as an indicator for EPI) from 61% to 92%, which is one of the highest levels in the African Region. Other achievements include the strengthening of the prevention and control of maternal and childhood diseases, malaria, HIV/AIDS and other major opportunistic infections and health risks.

## **3. Challenges for PHC implementation and recommendations**

- (i) Poor distribution of human resources within the country. For example, in regions such as Mopti, Kayes and Koulikoro, population per physician, nurse and midwife ratios in 2006 were inadequate and far short of the WHO targets for these categories.
- (ii) There is a need to increase the number of qualified health personnel.
- (iii) There is a need to mobilize more resources for health.
- (iv) The implementation of planned activities is low.

## MAURITANIA

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

After independence, health, as an important sector, was integrated into the Government's development policies. In the 1980s health policy was based on the PHC strategy aimed at bringing health care closer to the majority of the population. The country adopted the Alma-Ata Declaration, followed by the implementation of the Bamako Initiative in line with a WHO Regional Committee for Africa resolution in 1987. The training of community health workers started and continued during the 1979-1983 period. Several National Immunization Days were also organized in the 1980s indicating Government's shift towards community-based preventive health care.

The fourth national health plan (1981-1985) was the first to incorporate PHC principles as stipulated by the Alma-Ata Conference in 1978. In this new plan, emphasis was shifted to preventive care. Certain vulnerable population groups (women and children, rural/periurban populations and those living in poverty) were also identified for provision of priority health care. The plan envisaged the expansion of health services to attain 60% health coverage by 1985. The next health plan (1985-1988) prioritized the participation of the population and private sector in health care financing. The 1989-1991 plan made notable progress, putting emphasis on extension of health services coverage and increasing the proportion of the health budget in the overall state budget. The national health policy was formulated in 1992, based on the validation of the concept of the Bamako Initiative. It advocated cost-recovery as a strategy for increasing health sector financing at local level. The 1989-1991 plan promoted decentralization principles based on health centres, health posts and other health units at local level.

The country now fully endorses the PHC principles of decentralization, intersectoral collaboration, community participation and equity in health. In a 2005 document and a decree on poverty reduction, the PHC strategy and the Bamako Initiative are presented as cornerstones of government policy to reduce poverty and achieve health millennium development goals.

## **2. Actions taken to revitalize PHC**

The country adopted the Bamako Initiative as a mechanism for financing PHC activities at the grassroots level based on cost-recovery. PHC principles have been integrated into government policy documents that prioritize preventive care and accord special attention to vulnerable groups such as mothers and children and rural and periurban populations. A government decree made provision for free health care to patients suffering from tuberculosis and HIV/AIDS and people living in extreme poverty.

Cost-recovery schemes were introduced at each level of the health system. The cost of treatment of patients and payment options have been adjusted to make them affordable to the population (use of generic essential drugs, introduction of rolling funds, etc.). Some progress has been made in improving working conditions in health establishments. The introduction of several incentive schemes and retention of cost-recovery funds at health facilities have improved working conditions and boosted the job satisfaction of health workers.

The current 2005-2015 national health policy underlines the need to establish a modern and proactive health system that can deliver equitable and quality health care to all people in the country, thus contributing to improving life expectancy and the quality of life. To attain these objectives, the policy advocates the following three key strategies: (i) empowerment of the people for health matters; (ii) enhanced community participation in health; and (iii) intersectoral collaboration involving other sectors in health programmes and activities.

## **3. Challenges for PHC implementation and recommendations**

- (i) Despite the strong emphasis placed on service integration in existing documents and guidelines, actual integration at peripheral level is limited due to pressures from priority programmes and initiatives which are implemented vertically.
- (ii) Community-based health committee members are not well informed on their duties and decision-making powers. The participation of women, youth, local NGOs and associations in health activities is also weak.
- (iii) The quality of services provided poses certain problems. There are cases of stock outs at drugstores and the parallel drugs system is emerging, which compromises the cost-recovery system.

- (iv) The role played by regional hospitals, as the second referral level in the health system, is inadequate and needs to be strengthened.
- (v) There is no effective human resource management policy, resulting in the lack of staff at health posts and other PHC structures.
- (vi) There is a tendency to marginalize preventive health care in favour of curative care.
- (vii) Supervisory visits are formal and not formative, and advantage is not taken of the results of supervision. Supervisors often lose interest in monitoring their own recommendations made during their supervisory visits.
- (viii) There is a need to improve the management of financial resources for health.

## **MAURITIUS**

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

After its independence in 1968 and even prior to the adoption of the Alma-Ata Declaration, the health system in Mauritius was oriented towards the spirit of PHC as evidenced by the success of the family planning, malaria control, and polio eradication programmes and the control of other infectious diseases. Following the Alma-Ata Declaration, the PHC strategy was adopted and the targets harmonized with existing health priorities set under Health-for-All by the Year 2000 call. The development of the health system around PHC has long been recognized as the most cost-effective and efficient strategy in ensuring equity in access to quality health care. This is clearly demonstrated by the sustained efforts made to translate the philosophy and principles of PHC into concrete actions, notably the scaling-up of health promotion, preventive and essential curative care dispensed in the front line of the health care system and the promotion of participation by communities, stakeholders and other sectors.

The national health policies developed under the two successive national development plans (1980 -1982 and 1984 -1986) demonstrated the understanding of PHC and its relevance to the national context. The core focus was on: **(i)** bringing about a more *equitable distribution* of health resources with better access to PHC and its supporting services; **(ii)** paradigm shift from institution-based services to a more comprehensive *community-based health care system*; and **(iii)** *community participation* through social mobilization for health promotion and planning.

At the Ministry of Health and Quality of Life, a post of Principal Medical Officer responsible for PHC was established to be responsible for PHC health policy formulation and development and implementation of health care programmes. A joint UNICEF/WHO evaluation to determine the extent of implementation of PHC as an integral component of the health care delivery system concluded that all eight components of PHC were prevailing in 1985. The welfare state philosophy, which is deeply-rooted within the national health policy, where all health care services are provided free of charge to the end-user through government funding acquired through taxes, has largely ensured equitable access to PHC, especially among the underserved communities.

## **2. Actions taken to revitalize PHC**

A comprehensive review of the health sector was carried out in 1988 to assess the planning and organization of PHC at all levels. It resulted in the establishment of five autonomous health regions based on the recommendations of the WHO Regional Office for Africa on district health systems. Each health region was entrusted the responsibility for management of their respective health programmes while the role of policy formulation and coordinating rested with the ministry of health. In line with the review recommendations, the level of health services at the first point of contact with end-users was restructured: existing dispensaries, family planning and mother and child health (FP/MCH) centres and family planning service points were reformed as community health centres and existing health centres as area health centres. Their functions and the level of services provided were uplifted and their capacities strengthened. Qualified health personnel were assigned for PHC.

The public health sector has further developed its three-tier referral system with the increased resources allotted to the PHC level. The PHC network currently comprises 112 community health centres (CHCs), 21 area health centres (AHCs), 2 medi-clinics (MCs) and 2 community hospitals (CH). These peripheral units have a multidisciplinary team, namely Medical/Health Officer, Dental Surgeon, Community Health Nursing Officer, Dispenser and Health Inspector. The basic services delivered at the CHC include the treatment of common diseases and injuries and MCH/FP care. In addition to the services available at CHC, the MCs/AHCs also provide x-ray, dental care, laboratory tests and pharmaceutical services for essential drugs. The middle-level consists of two district hospitals. The referral level is made up of regional hospitals (five) and specialized centres (five), providing specialized in-patient and out-patient care. Fifty CHCs, each catering for a population of around 5000, were set up by end 1989. The entire population

has reasonable access to the first point of contact with the health system (CHC and AHC) within a radius of  $\leq 5$ km.

In 1994, a study to assess the extent to which local health committees (set up to manage CHCs) have empowered the community to shape up and influence their health outcomes was carried out. This culminated in the development and implementation of a national action plan to improve performance at community level. With the rapid epidemiological transition and shift in the burden of diseases to chronic diseases, the revitalization of PHC is an ongoing process with the strengthening of the primary and secondary care intervention programme for noncommunicable diseases (NCDs) and their risk factors. With a view to bringing PHC to the doorsteps of the population, the NCD mobile screening services (diabetes, hypertension, breast and cervical cancer) have been scaled up. Institutionalization of training programmes was carried out for all newly recruited community nursing officers and community health workers with special focus on PHC. In view of the rising incidence of mental health illnesses, the PHC package has been expanded to include mental health services. This is expected to facilitate the integration of persons with mental health disorders in the community. To promote the integration of mental health care and support at PHC level, training programmes for medical health officers, community nursing officers and community-based rehabilitation workers are underway.

The pursuit of a strategy based on PHC and its core principles has been determinant in ensuring that the health-related MDGs are well on target. Over the period 1978 -2006, the under-five mortality rate dropped from 40.9 to 16.1 per 1,000 live births; the infant mortality rate dropped from 33.9 to 13.5 per 1,000 live births; and maternal mortality ratio decreased from 99/100 000 to 18/100 000 live births. Current immunization coverage against tuberculosis, diphtheria, whooping cough, tetanus, poliomyelitis, measles, mumps and rubella is levelling the 89% mark in the public health service. This is complemented by the private health sector which accounts for approximately 8%.

### **3. Challenges for PHC implementation and recommendations**

- (i) Health care facilities at PHC level are not optimally utilized as there is a misuse of the referral system. Whilst patients are required to present initially at the primary level, then progressively referred to district, regional or specialized hospitals depending on the complexity of the illness, many users bypass the referral network. District, regional and specialized institutions now function as first care facilities, thus resulting in the inappropriate use of resources.

There is a need for an integrated monitoring and evaluation system for all programmes under PHC.

## **MOZAMBIQUE**

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

Since the signing of the peace agreement in 1992, Mozambique has made significant recovery from its war-torn past. A rapidly growing economy, debt relief under the Heavily Indebted Poor Countries initiative and a steady increase in external aid coordinated through a sector-wide approach (SWAp) have led to a significant increase in resources and positive socioeconomic development. The Government has made it a national priority to combat poverty as a precondition for growth and development as well as to meet enormous challenges posed by major infectious diseases and the poor health status of women and children.

Despite huge investments in the health sector, inequities in health persist. The country has a health system based on primary health care (PHC) principles. The commitment to strengthen the PHC approach as a means of improving the health status of the population has been reflected in several policy and strategy documents. PHC has been integrated as part of the four-tier health system. The main elements of PHC are being applied with focus on disease prevention and health promotion. These include child immunization, growth monitoring, pre- and post-natal care, attendance at birth, first-aid, routine consultations for adults and children, family planning, school visits and hygiene inspections. These elements are part of the basic package of essential services which is offered through the primary level health facility network.

## **2. Actions taken to revitalize PHC**

The ministry of health (MoH) has just finalized and costed the 2008-2012 health sector strategic plan which reflects strong commitment to expanding health services to a larger proportion of the population with a special focus on vulnerable groups and communities in underprivileged areas. Improving access to quality health services by increasing coverage of health facility networks, addressing the human resources crisis and strengthening community-based services and community participation are the main priorities to be addressed.

The lack of human resource capacity has been defined as one of the greatest barriers to overall health sector delivery. The MoH is in the process of developing a human resources plan for the next seven years. Staff motivation and productivity, incentive policies for deployment to deprived areas, review of career perspectives as well as training needs are important for ensuring a sufficient workforce at the primary level. Revitalization of the community health workers programme is seen as an essential measure to bring basic health care services to large parts of the country where there are no health centres. The user-fee policy is under review and findings of a study on the impact of abolishing user fees are being finalized. The review of national health accounts is ongoing and will provide more insight into health expenditure patterns and financing. This will allow for a more informed budget allocation process, which will benefit the primary care level.

The MoH is currently planning to conduct a study on decentralization to reinforce the organization and delivery of health services in a decentralized public sector. A Traditional Medicine Unit was set up at the National Institute of Health in 2006, thus recognizing the importance of traditional medicinal practices in a socio-cultural context and its complementary role in institutionalized care. The MoH is in the process of setting up a national committee on social determinants of health which aims to approach health from a broader intersectoral perspective. Such approach is necessary to address issues outside the traditional domain of the health sector such as access to safe drinking water, sanitation, waste control and transportation and communication systems.

### **3. Challenges for PHC implementation and recommendations**

- (i) There is a need to review and implement a wider range of services which are responsive to individual and community needs, e.g. decentralized care for tuberculosis and HIV/AIDS patients, and eye and dental care.
- (ii) Upgrade and expand the primary health facility network.
- (iii) Resolve the issue of essential commodity shortages, such as water, electricity, communication and transport, and equipment.
- (iv) Increase the workforce at the primary level, deploy a greater number of more qualified health staff to geographically unattractive areas and reinforce measures to increase staff performance and motivation.
- (v) Revitalize the community health workers programme backed by a clear policy which includes remuneration of community health workers.
- (vi) Health planning processes should integrate more horizontal-community health strategies and vertical programmes.
- (vii) Mobilize more financial resources and increasingly redistribute them for primary health care. This also implies the harmonization and coordination of global health initiatives supporting health system components and not just priority programmes.
- (viii) Build capacity in district management, planning and local governance.
- (ix) Ensure regular supervision of the primary level and pay more attention to the monitoring of district performance and health outcomes.

## NAMIBIA

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

At independence (1990), Namibia inherited a health service structure that was segregated along racial lines and based on curative health services. There were large inequalities in the delivery of health care services. The Government adopted the PHC approach as a strategy to achieve community participation in health supported by CBOs, NGOs, faith-based organizations (FBOs) etc. PHC is guided by seven principles as outlined in the MoHSS 1998 policy framework “Towards achieving health and social well-being for all Namibians”: *Equity, Availability, Accessibility and affordability; Community involvement, Sustainability, Intersectoral collaboration and Quality of care*. PHC is recognized as an integral part of health promotion and social development contributing to quality of life. It is seen as a cost-effective approach for delivering health services in an integrated manner. All the health chapters of the National Strategic Plan: Vision 2030, the National Development Plan, Poverty Reduction Strategy and HIV/AIDS Medium Term Plan, are based on the PHC approach which was used to guide the restructuring of the health sector.

In line with its objective of achieving health for all Namibians, the government has been shifting resources to the disadvantaged regions, focusing on preventive services and basic care through clinics, mobile health teams and outreach structures to ensure that free health services are decentralized and reaching all people in rural areas. Regions and districts plan their own activities, cost them and receive budgetary allocation according to their needs.

## **2. Actions taken to revitalize PHC**

About 45% of the budget of the MoHSS, complemented by funding from development partners, is allocated to the implementation of PHC services. New health facilities have been built and health workers have been trained in participatory rural appraisal (PRA) techniques to enable them to work with communities. This forms a support mechanism to Community's Own Resource Persons (CORPs) in Community-Based Health Care (CBHC) activities. The Official National PHC/CBHC Guidelines were launched in 1992. They provided a base for decentralization and intersectoral collaboration with identification of community needs by all sectors and NGOs. Community health committees were established focussing on health and social services. These and health committees at district and regional level ensure close collaboration between them and MoHSS. Over 20,000 community volunteers were trained and more than 10 000 home-based care kits purchased by MoHSS to care and offer psycho-social support for the sick and their families.

An assessment of community volunteers was carried out in 2006. Communities are also involved in baseline surveys and other community-based research. The capacity of communities has been enhanced through the re-orientation of traditional birth attendants (TBAs) and community health workers (CHWs) in PHC/CBHC, participatory rural appraisal techniques and in various aspects of community health. Nurses, environmental officers and medical rehabilitation workers are trained in community health. A National Community Volunteer Conference was held in 2006 to update the CBHC policy. Some specific PHC activities include: establishment of orthopaedic technical services mobile clinics at various locations; development of regional action plans for food security and nutrition and gardening projects at the different health facilities in the regions; establishing goat farming projects for disadvantaged communities; nominating community counsellors for HIV/AIDS projects; assigning field promoters for tuberculosis DOTS programme, including TBAs and traditional healers in disease surveillance committees; etc..

## **3. Challenges for PHC implementation and recommendations**

- (i) Diverse cultures and traditions have made it difficult for the PHC approach to be universally accepted, resulting in a decline in community participation. The roles of VDCs and VHCs are not well understood by the communities. In addition, these committees are not fully functioning and community health projects are not sufficient. Community health resource people (CORPs) do not receive adequate support from the communities they serve.

- (ii) Stakeholders should collaborate and coordinate their strategies in supporting community volunteers and engage communities to be fully involved in planning, monitoring and evaluating community-based health care and social activities.
- (iii) For some PHC programmes, there is no appropriate and reliable indicators to guide, monitor and evaluate CBHC activities at operational level. This has resulted in poor supervision and inadequate reporting from districts and regions.
- (iv) At the operational level, the health information system and operational research are limited due to inadequate infrastructure and human, material and financial resources.
- (v) There is a need to strengthen capacity building of health workers through integrated training on health policies and guidelines.
- (vi) There is a huge scarcity of relevant professionals, e.g. orthopaedic surgeons, ophthalmologists, nurses, environmental health officers, dieticians and nutritionists. High staff turnover is also contributing to staff shortages.
- (vii) Transport life-span decreases fast due to long distances and lack of maintenance of equipment and transport.

## **NIGER**

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

PHC is integrated as part of the health system with focus on preventive, curative and promotive care delivered to all communities with their full participation. The PHC approach was reaffirmed by the health sector policy declaration adopted by the Council of Ministers in 1995. The main strategy for policy implementation was the Three-Phase Health Development Scenario which sought to operationalize districts through coherent actions at central, intermediate and local levels with the participation of communities. In line with this policy the Government decided to prioritize the preventive approach to health through sensitization and education of the population, expansion of health service coverage, strengthening of environmental sanitation, immunization, mother and child, essential drug programmes, etc.

Government policy also included the reorientation of investments towards these programmes and creation of favourable conditions for disadvantaged population groups based on national solidarity. The policy regarded the district as the basic level of the health system of Niger for local health development and implementation of the PHC strategy.

## **2. Actions taken to revitalize PHC**

In 2002, the national health policy was reviewed and new programmes were added such as reproductive health, family planning, nutrition, and control of HIV/AIDS and sexually transmitted infections. The review strongly recommended full decentralization of health centres to bring health care closer to the population. To implement the revised policy, several PHC-related strategies were proposed: strengthening of district health systems through decentralization; further expansion of health coverage through district planning which should include private facilities, mobile activities and care of nomadic populations. The new orientation also made provision for strengthening priority disease surveillance, essential drug and traditional medicine programmes, community information and education, promotion of reproductive health, community participation and environmental health. By decrees issued in 1996 and 1999, a network of “community units” and integrated health centres were established to provide community health care through the essential health activity package. Thanks to this network, health care coverage (within five km from the nearest health centre) increased from 47.6% in 2001 to 65.0% in 2005.

Health units are community-based and provide a health care package with first-level interventions such as identifying sick people and referring them to integrated health centres, providing health education and home-based care, taking care of pregnant women and patients with chronic diseases and advising on family planning. Since the adoption of the health sector policy in 1995, the government has embarked on the transformation of old medical centres into district hospitals with the support of bilateral and multilateral partners. There are now 42 district hospitals which provide referral services including hospitalization, laboratory tests, x-ray screening, etc.

In 1996, health teams were formed and their members trained in management with WHO support. This type of training was institutionalized in 2002 by the Quallan Training Centre. Various training programmes are integrated into the curriculum of training institutions (IMCI, RH/FP, EPI, etc.).

To address equity and urgent health needs of disadvantaged populations, the government, during 2005-2006, introduced free health care for pregnant women, as well as for under-five children, free prenatal consultations and family planning, which resulted in increased use of health services. Because the country is prone to epidemics, epidemic surveillance centres and epidemic management teams were established at district level with membership from communities, NGOs and associations.

A rural pilot project (Torodi council) covering 134 000 inhabitants was implemented with partner support to improve water supply and sanitation at household and community levels. Phase 2 of the project includes improvement of sanitation of five schools in urban areas.

### **3. Challenges for PHC implementation and recommendations**

- (i) There is a concern that, due to lack of skills of district health workers in resource mobilization and management, decentralization to the district level may not bring about the expected outcomes and may end up with lack of resources at operational level to support planned activities.
- (ii) There is also concern that peripheral health unit staff may be unprepared to assume new financial and administrative functions resulting from decentralization.
- (iii) The central and regional levels lack the necessary skills to ensure formative supervision.
- (iv) There is insufficient orientation and training of district health teams on their tasks and responsibilities.
- (v) Community participation in health management is often not effective due to failure by officials to perform their duties (low commitment, absence of incentives, no experience in community sensitization techniques, etc.).

## **NIGERIA**

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

The development of the health system and PHC in particular are based on a national philosophy in Nigeria that governs general development. Since the country became independent in 1960,

great efforts at development have led to the formulation of various national development plans with health as an important component. A major ingredient in all of these plans was the health of the population which was seen as a stimulus of economic growth and social development. In 1988, the national health policy based on principles of social justice and equity was formulated. Consequently, PHC was adopted as the cornerstone of the health system. During this period, the Bamako Initiative was adapted for the provision of essential drugs in all Local Government Areas (LGAs) which gave a further boost to the PHC concept.

Nigerian health services are organized along the three tiers of Governments as follows: **Primary care** is largely the responsibility of local governments, with the support of the State Ministry of Health and the Federal Government; **Secondary care**, which provides specialized services to patients referred from the PHC level, with responsibility of the State Government; and **Tertiary care**, which provides highly specialized services, referred from the primary and secondary levels, is the responsibility of the Federal Government. The overall objective of the national health policy is to improve accessibility of the population to primary care as well as secondary and tertiary care.

The Nigerian national health policy as reviewed in 2004 identified PHC as the main focus for delivering a minimum health care package to the population through four approaches: promotion of **community participation**; improved **intersectoral collaboration** in primary care delivery; enhanced **functional integration** at all levels of the health system; and strengthening of the **managerial process** for health development. For Nigeria, this package includes all health interventions and services that address health and health-related issues. Another way of integrated delivery of PHC is the recent identification of the ward as the unit of PHC deliveries to the population. Each ward has a Ward Development Committee with members from various sectors.

## **2. Actions taken to revitalize PHC**

Ministries of health at both national and state levels were restructured to give prominence to PHC. In a bid to institutionalize PHC services and ensure sustainability, a decree was promulgated in 1992 establishing a National Primary Health Care Development Agency at the federal level in an effort to ensure sustainability of the PHC movement that was started. This Agency has a mandate: to support and periodically monitor and evaluate the national health policy, as it relates to PHC at all levels; mobilize resources nationally and externally for the development of the PHC and, most importantly, provide technical support; coordinate and

develop strategies for the effective implementation of PHC nationwide. A new health bill has been issued to rationalize the relationship between the Agency and State and Local Government services. A plan of action (2006-2010) was developed for the minimum health care package which includes the following health interventions: Control of communicable diseases (malaria, HIV/AIDS/STD, TB); Child survival (IMCI, routine immunization), Safe Motherhood; Nutrition; Non-communicable disease prevention; Health education and Community mobilization.

Recently the Integrated Management of Adult Illnesses (IMAI) with strategies to scale up HIV/AIDS control interventions through the PHC system was introduced. Other initiatives related to the Polio Eradication Programme include the Reaching Every Ward (REW), Immunization Plus Days, micro planning, data management and monitoring. These initiatives are all implemented within the confines of PHC and have positively strengthened the system.

### **3. Challenges for PHC implementation and recommendations**

- (i) There is widespread misunderstanding about essential concepts of PHC as a “primary” or “simple” care. Such misunderstanding is found not only among the lay public; surprisingly some health professionals and decision-makers do not seem to have a clear idea about PHC.
- (ii) The limited involvement of communities in the PHC movement is the most significant factor that has inhibited health development in Nigeria. The occasional consultations and retreats with selected informants do not make up for the need to establish a process in which communities participate through the involvement of their credible representatives. There is still a tendency to pronounce policy changes without adequate consultation with the communities.
- (iii) The delegation of primary care to Local Government was intended to bring decision-making and services close to where people live and work. In practice, the primary care, the critical foundation of the health system, was allocated to the weakest and poorest tier of Government. Since PHC is the bedrock of the health care system, its adequate funding and effective management should be the concern of all the three levels of Government and shall not be the responsibility of the local governments alone.
- (iv) Although Nigeria has made a political commitment to PHC since the mid-1980s, this was not translated into financial commitment in terms of adequate budgetary allocation to it. Until effort is made by the Government and other stakeholders to significantly

contribute to the financing of PHC in the country and broaden its resource base, PHC will continue to be under-funded and its proven cost-effective interventions will continue to be inaccessible to many Nigerians.

- (v) The National PHC Development Agency was largely established to interpret and support policies, provide guidelines and coordinate the implementation of PHC. Some of these functions have been eroded or taken over by other units of the Federal Ministry of Health, leading to the wastage of resources. It is recommended to establish a State PHC Board and a Local Government PHC Authority.

## **RWANDA**

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

The concept of PHC defined in Alma-Ata in 1978 has tremendous influence in health system development in the country with social, cultural and economic impact on health policy. The PHC concept was adopted before 2005 by decentralizing the health system to district and community levels. After 2005, with administrative reform, the district became the centre for health development, providing health services to about 200 000 people with 10-15 health centres having 8-10 health units each. Each of these districts has a hospital and a health centre.

As health units are the closest administrative units at community level, it is planned to have one health post for each unit run by a nurse and a health promotion worker. Currently, each village has two community health workers (male and female) in charge of disease prevention programmes (malaria, acute diarrhoea, chronic diseases, HIV/AIDS, TB, health education, etc.).

The national health policy is based on PHC and the Bamako Initiative principles which imply equity in access to health care, financial accessibility to services and community participation. It also provides for a package of health interventions to be delivered through insurance schemes to all members participating in the schemes. Community participation is the cornerstone of PHC implementation. The main community health actors are community health workers who play an important role in disease prevention.

## **2. Actions taken to revitalize PHC**

To address constraints on financial resources accessibility by the people, health insurance schemes were introduced in 2003. Currently, about 70% of the population benefit from this initiative. Some private insurance companies also provide cover to servicemen, policemen, etc.

To ensure staff retention, the Government introduced a contract scheme by which the candidate enters into contract with health institutions for a certain period for an agreed salary. Due to expansion of PHC activities, the prevalence of HIV has decreased to 3%. Mortality from malaria is also declining as a result of the introduction of home-based case management. The achievements of the immunization programme are impressive, judging from the DPT3 coverage rate (97%), which is one of the highest in the WHO African Region. Efforts have been made to improve diarrhoeal case management in under-five children. Activities at community level have led to improvements in individual and collective hygiene.

## **3. Challenges for PHC implementation and recommendations**

- (i) There is low awareness of health issues among the population.
- (ii) The training of health personnel is inadequate.
- (iii) Materials and equipment supplied to health facilities are insufficient.
- (iv) The utilization of services provided by health establishments outside insurance schemes is declining as the people prefer to use health facilities where services are covered by an insurance scheme.

## **SAO-TOME AND PRINCIPE**

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

The primary health care (PHC) concepts defined in Alma-Ata in 1978 were adopted by the Government as an essential strategy for health promotion. PHC offers services which are accessible to individuals, families, communities and are carried out with community participation. This strategy is highly appropriate to the country where 50% of the population are poor and the national health system is weak. In addition, the health system in the country is

oriented towards curative care services provided by hospitals which are hard to access by vulnerable and marginalized population groups. The national health policy of the country is in line with PHC principles which advocate universal coverage of the population at all levels, equity in access and utilization of services without any prejudice. The policy also emphasizes the importance of the integrated delivery of services and optimal use of resources at each level.

Individual programmes such as HIV/AIDS, IMCI, EPI, and Reproductive Health have been decentralized and are implemented in an integrated manner. Communities are involved in health matters and actively participate in decision making. Health posts were set up in response to the demand of communities; water supply and sanitation programmes are developed in consultation with communities which are involved in construction work and the protection of water sources.

## **2. Actions taken to revitalize PHC**

After the adoption of the PHC approach, the ministry of health embarked on decentralization of health service provision to improve access to essential health care. This was achieved by creating health zones and strengthening district health systems, providing them with infrastructure, human resources, equipment, drugs and consumables. The minimum health package was also defined. Today, the peripheral health system comprises 7 health centres, 21 health posts and 21 community health posts with 160 community health workers.

The integration of health services was one of the main concerns of the ministry of health. To address this concern, it provided multidisciplinary training to health personnel. A national health map was developed following the survey conducted in 2000 on the level of health coverage by district which varied between 78.9% (Principe Region) and 97.0% (Agua Grande District). The survey also identified districts where more health units need to be established to improve access to health care. Significant achievements were recorded by the immunization programme: EPI coverage which was 40% in 1990 stands at 80% today. Capacities for diagnosis and treatment of diseases were reinforced in five districts through the provision of human resources, diagnostic equipment and laboratory supplies.

### **3. Challenges for PHC implementation and recommendations**

- (i) Lack of financial resources for health.
- (ii) Low motivation of health personnel.
- (iii) Low managerial capacity at each level of the health system.
- (iv) Poverty is one of the major constraints to health development.
- (v) In-service training of community health workers in the provision of integrated health care and supervision is needed to improve their performance. In addition, a mechanism for boosting staff motivation should be put in place through operational research.

## **SENEGAL**

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

The Government regards health as a foundation for national development. It prioritized rural health in two regions and in 1972, based on this experience, introduced administrative reform to decentralize the country's health system in order to increase access to health care. The reform was reinforced by the adoption of the PHC strategy in 1978. The system was further decentralized to increase accessibility of health services. The referral system was improved through health centres and hospitals in line with the Three-Phase Scenario.

Health personnel were integrated into the new system which was oriented towards the involvement of communities and other sectors in health. The ministry of health (MoH) was also restructured, creating new divisions of PHC and Operational Services to manage the construction of health facilities, renovate equipment, and improve the capacity of training institutions. A PHC supervisory team was formed with supervisors at regional and district levels.

In 1979, the Government reinforced the health policy through a structural reform of the ministry of health. A number of directorates, namely planning, referral systems, protection of the environment and hygiene, general administration, pharmaceutical services, etc., were created. The goal of the policy was to ensure that all people enjoy complete physical and mental well-being, a concept which was reflected in the fifth and sixth national development plans. The

objective of the fifth plan was to implement the PHC strategy throughout the country by encouraging rural communities to set up committees for the implementation of administrative reforms, and to provide rural populations with quality curative and preventive health care. The national plan also provided for the putting in place of a number of programmes (EPI, Nutrition, Environmental Health and Health Education) to be implemented by multidisciplinary personnel.

After the Alma-Ata Declaration, numerous decrees, declarations, development plans and circulars were issued showing high commitment by the Government to the decentralization of health services, community involvement in health, intersectoral collaboration, etc. The PHC approach was reaffirmed by the introduction of the Bamako Initiative in 1992 which called on communities to participate in health financing through cost-recovery. A mechanism was put in place to support the poor identified by communities. The country's health policy advocates the provision of integrated PHC services at regional, district and local levels. At the central level, the integration of health services is coordinated by the Integrated Health Development Programme. New cadres were trained to implement PHC at grassroots level namely community health workers, hygienists, etc. The participation of communities in PHC implementation took different forms: construction of health facilities, latrines, participation in health financing, distribution of health packages, establishment of health committees and community health insurance schemes, monitoring and evaluation of health programmes.

## **2. Actions taken to revitalize PHC**

The population policy declaration with a number of references to health was released in 1988 and revised in 2002, followed by the health policy declaration in 1989. The new health policy orientation was undertaken in 1995 and a sectoral policy paper was issued in 1997. These basic documents and initiatives were accompanied by a number of health sector reforms including planning the decentralization process based on established norms, defining essential drug policies (1989), putting in place of a project on the development of human resources for health, creating health districts (1991), passing a law on health committees, etc. A number of projects were initiated on community participation, and health promotion supported by the Government and partners (USAID, OSB, SIDA, PRN, local NGOs, etc.). The aim of these projects was to strengthen PHC through health information and communication, community participation in the construction of health infrastructure, control of diseases, etc.

The Pikine PHC project covered the periurban areas of Dakar and helped to construct drug depots, renovate health centres, train health personnel, etc. The Sine Saloum project supported the construction and renovation of health posts, drug depots and training of community workers. The Grandmother project showed the role of elderly people in the promotion of mother and child health. Thanks to community surveillance and control measures, guinea worm has been eradicated in Senegal (certified by WHO). In 2004, a strategic plan was developed to address the need for intersectoral collaboration including the private sector. The IMCI programme is currently being tested to further expand the integration strategy. A new policy document on community health is being prepared.

### **3. Challenges for PHC implementation and recommendations**

- (i) Insufficient political commitment at higher level regarding several health reforms which had not been implemented.
- (ii) Difficulties in the mobilization of financial resources.
- (iii) The decentralization of resources is insufficient.
- (iv) There is a need to further expand health coverage.
- (v) Poor performance by the health sector and lack of a monitoring and evaluation system.
- (vi) Lack of a policy on community health workers.
- (vii) Motivation of community health workers is a serious challenge.
- (viii) Certain programmes and interventions are not institutionalized in the school system (EPI, HIV/AIDS, STI, etc.). Schoolchildren are therefore not sufficiently sensitized on reproductive health issues and HIV/AIDS.
- (ix) Multisectoral management at central level is inadequate due to the existence of many coordination and management structures (regional, departmental and local development committees). Many of these structures are not working efficiently and health is not being considered as a foundation for development.
- (x) Weak involvement of the private sector in public health is a major challenge and should be addressed by putting in place a mechanism for public/private mix ventures. Clear procedures and guidelines are needed to improve private sector involvement in public health in general and PHC in particular.

- (xi) The existence of many interventions and programmes in the PHC package often hinders the operationalization of the PHC concept because health workers with different skills are needed to manage and supervise the programmes. Owing to the shortage of staff at health centres and health posts, the provision of integrated curative, preventive and promotive care is a challenge for health workers.

## **SIERRA LEONE**

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

PHC is not a new concept, nor is it something separate from existing services. One of the main functions within the Ministry of Health and Sanitation (MoHS) is to create an organizational system to run the PHC service. Government is aware that improvement of health results from genuine economic growth and that investment in health is essential for development. Social justice demands that all sections of the population enjoy a fair share of the national income and a service including health.

The national health policy was formulated in 1993, followed by the national health action plan in 1994 which is now being implemented. Building and equipping of PHC by various national and international organizations (WHO, EU, World Bank), establishment of training institutions for community health officers and MCH aides and development and strengthening of health information systems have contributed to the strengthening of health systems. The process of decentralisation and its sustainability constitute the fundamental platform for the comprehensive implementation of all components of PHC services. The local councils in all the 13 districts are stakeholders in health service delivery. PHC is now being implemented in an integrated manner using the multisectoral approach. This effort started with campaigns but is becoming part of routine PHC services.

Following the Bamako Initiative and as a further development in the implementation of the Essential Drugs Cost-Recovery programme in 1986/1987, the Ministry of Health and Sanitation began the process of incorporating this strategy into its health policies. A committee of experts was appointed to prepare a programme proposal for the implementation of MCH/PHC according to the BI strategy phased towards a national coverage. Government has focused policies on the development of promotive, preventive, curative and rehabilitative services. This development is

expected to continue and to intensify with the setting up of medical manpower training institutions so as to provide a constant supply and ensure the retention of all categories of manpower needed to effect PHC and other health care programmes nationwide.

Full participation and involvement of community members in any activity affects their health and well-being. Individuals, family and community members perform most of the health care activities: take children for vaccination, prepare and administer oral rehydration solution, decide when and where to go for any health advice or assistance, etc. The creation of the Ministry for Gender and Children's Affairs underlines government awareness of the needs of the most vulnerable group and commitment to address these needs.

## **2. Actions taken to revitalize PHC**

To unify the PHC approach, the national guidelines "The National Operational Handbook for PHC" was developed (1987) and regularly updated. A further series of national workshops for district staff were held to discuss the detailed implementation of PHC. Special attention was given to the development of Peripheral Health Units (PHU) and training of auxiliary staff. To strengthen and enhance PHC implementation, the ministry of health is now designated the Ministry of Health and Sanitation (MoHS) to emphasize the environmental sanitation aspect of its functions. The Directorate of PHC was created to oversee the 13 programmes focussing on particular aspects of PHC, among them: District Health Care, Health Education, Nutrition, Environmental Sanitation, RH/MCH, School Health, Mental Health, Oral Health and Community-Based Rehabilitation. Planning at the micro level by various directorates is ongoing and is a regular process. Detailed district plans are developed.

The MoHS has administered a revolving fund for essential drug purchases with UNICEF incorporating cost recovery from the community. All of the 13 districts in the country have initiated activities to strengthen PHC. To increase accessibility to health care, the Peripheral Health Network comprising of Peripheral Health Units (PHU) which are the PHC delivery points was established. There are three main types of PHUs which are recognized and standardized with clearly defined functions. The buildings, equipment, drug supplies and staffing levels are specified to meet these functions. District Health Management Teams were formed to administer health services, equip, train and supervise the PHU staff. A District Task Force was established which supports and coordinates all health and development activities, manages funds and other resources, especially during emergencies. The community-based structures also include **the Community Health Centre (CHC)** situated in the Chiefdom Headquarters or in a

well-populated area having a catchment population of 5,000-10,000 within a 5-mile radius. These centres have preventive, promotive and curative functions. In addition to its own catchment area, the CHC oversees all the other units in the Chiefdom that is, the Community Health Posts and the MCH posts, as well as the community health workers.

A series of intersectional, regional and national workshops to discuss the concepts of PHC were held in Kenema, Bo, Makeni and Freetown during 1982/83. The Government has encouraged the development of several projects, which support the PHC approach, funded and organized by NGOs. The two largest projects were those at Bombali, supported by UNICEF, WHO and a Catholic Church agency. The second was the GTZ-funded Bo-Pujehun project in the Southern Province. The Government/WB Health and Population Project (HPP) in 1986 supported PHC in Kenema, Moyamba and Tonkolili Districts. These were maintained by the collaborative inputs of the Government and UNICEF. Plan International supported the Rural Western Area PHC Programme in 1993. In furtherance to government commitment to PHC the European Union (EU) is supporting PHC in Kailahun, Kambia, and Pujehun Districts respectively. A five-year programme proposal to proliferate community-based MCH/PHC nationally, between 1989 and 1993, was finalized by the MoHS, in collaboration with UNICEF and WHO. This proposal sought to develop the introduction of the community financing of PHC-component services and achieve the self-sustainability of PHC, which had not been fully taken into consideration previously.

### **3. Challenges for PHC implementation and recommendations**

- (i) Low coverage of PHC services.
- (ii) Weak preventive/promotive services and inadequate curative services.
- (iii) Lack of human resources.
- (iv) Poor health education of population.
- (v) Lack of sustainable financing systems.

## **SOUTH AFRICA**

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

The country aligns itself with the Alma-Ata Declaration on primary health care (PHC) which is understood as essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally acceptable to individuals and families in the community through their full participation and at an affordable cost and sustainable at every stage of their development. PHC forms an integral part of the country's health system of which it is the main focus, and of the overall social and economic development of the community. It is the first level of contact with the national health system (NHS) bringing health care as close as possible to where people live and work.

The WHO District Health System (DHS) approach was adopted in 1994 as a vehicle for PHC delivery system. It recognizes decentralized health management and integrated health programmes and includes all health care activities both public and private, NGOs, civil society and other stakeholders. In 1994, the Government of National Unity inherited a highly fragmented, discriminatory and bureaucratic health system. The political commitment was to ensure equity in health delivery and resource allocation which needed restructuring of the health system. It is on this background that the NHS was adapted to address and redress inequalities through DHS with PHC as a health delivery approach.

The new system, based on "Batho-Pele" (People first) principle, the "Health Rights Charter" and "Patient Rights Charter", emphasized equity in health through devolution and decentralization of authority to district level to ensure universal access (within 5km radius), private-public partnership, appropriate and rational planning, and efficient use of resources tailored to local health needs. These principles were clearly articulated in the health reform policy (White Paper on transformation of the health system in South Africa) issued in 1997. The integration of health care delivery is assured by introducing a PHC intervention package and setting norms for delivery practices. There is a tremendous enthusiasm among the population to participate in health matters which is being realized through their participation in health committees (including women), negotiations on PHC package with the providers, electing representatives on health matters, periodic health summits ("Health Imbizos") and "Youth Indabas", raising health concerns to be discussed and resolved by parliamentarians.

## **2. Actions taken to revitalize PHC**

The health reform policy introduced in 1997 brought about global changes in the health sector of South Africa. It served as a basis to develop a five-year document called “Strategic Priorities for the National Health System, 2004-2009”. DHS policy was implemented to strengthen the integration of fragmented health services. Re-demarcation of district boundaries led to the rationalization and creation of 52 new health districts (formerly there were 174 health districts and 843 municipalities). Curative services were added to the municipal PHC package to make the PHC a comprehensive entity to deliver promotive, preventive, curative and rehabilitative care. Overlapping and duplication of services between provincial and municipal health clinics were eliminated by rationalizing their functions and responsibilities. Health facility working schedules were reviewed to make the services available on a daily basis. A supermarket approach was introduced at health facilities to promote the integration of services and prevent missed opportunities for immunization and other interventions (weighing babies, deworming, providing health messages, etc.). The country has also prioritized health care quality issues as reflected in the document “Policy on Quality of Health Care for South Africa” (2007).

In 2006, the Health Act was drafted and put in action with its chapter 5 emphasizing the PHC approach in health service delivery. A number of ongoing initiatives have been launched to improve health outcomes such as the Integrated Sustainable Rural Development Programme (ICRDP) targeting rural areas to contribute to the socioeconomic well-being of rural folks. There is also a multisectoral initiative called Urban Renewal Programme (URP) to improve informal settlements in big towns. This is a venture with collaboration between Government departments (Health, Housing, Education, Environment) and parastatals such as Eskom and Telekom.

## **3. Challenges for PHC implementation and recommendations**

- (i) Availability of health services in some rural settings on regular bases (e.g. daily) is hampered by lack of health personnel.
- (ii) Brain drain of health personnel having a multiple pattern: from rural to urban, public to private and from South Africa to countries in Europe or Australia.
- (iii) Fragmentation of health programmes (though it is recognized that some programmes such as TB, HIV/AIDS, EPI and Malaria control may need certain verticality for their effective monitoring through specific indicators).

- (iv) Deficiencies in the functioning of the referral system which at times are related to communication failure between health institutions within the referral system.
- (v) Low resource-absorption capacity of the health sector which results in inadequate utilization of resources.

## **SWAZILAND**

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

The government of the Kingdom of Swaziland adopted the concept of primary health care (PHC) and defined it as the provision of essential health care that is affordable, accessible and acceptable to the Swazi population. The national health policy developed in 1983 was based on the principles of PHC which announced a shift from urban-based curative health care services to rural populations with preventive and promotive health services. The policy stated that the Ministry of Health and Social Welfare (MoHSW) is committed to the WHO goal of Health-for-All by the Year 2000. It also stressed that the strategy of the ministry is to achieve this goal by mobilizing all for health in the development of a comprehensive primary health care system comprising preventive, promotive, rehabilitative and curative care which is relevant and accessible for all.

The core strategy to achieve this goal which was selected by the ministry was decentralization. In 1984, the decentralization system defining the roles for each health system level was developed and put into action in 1985. The functional committees and subcommittees were also put in place with clear terms of reference and specific roles in developing and monitoring PHC implementation. The composition of these committees included community members to ensure community participation in health matters.

### **2. Actions taken to revitalize PHC**

A Policy and Planning Committee (PPC) was established at national level for policy formulation and guidance, resource allocation, technical supervision and monitoring. These functions are implemented through subcommittees, such as Training and Personnel, Budget Preparation, Management Subcommittee, etc.

In an effort to ensure that the decentralization took place, the ministry established a Decentralization Task Force which comprised the ministry's senior staff as well as regional health administrators. The major role of the Task Force was to plan and set targets and time schedules for the design and implementation of the decentralization process. At regional level, the ministry established Regional Health Management Teams (RHMT) to develop and supervise integrated health services in the region including government, faith-based and private health services. By the recommendation of the Task Force, health committees were also established at hospital, health centre and clinic level with membership of health team and community members. Village leaders identified community members who were trained by the MoHSW as Rural Health Motivators. Their major role is to motivate community members to seek medical care and take children to health facilities for growth monitoring, immunization and treatment for minor ailments. They are also trained to provide basic first aid such as giving oral rehydration salt to patients with diarrhoea before referring them to the health facilities. This cadre has become a powerful resource within the communities. As a result, there were considerable gains in the health system evidenced by improved health indicators of some priority programmes (e.g. immunization).

### **3. Challenges for PHC implementation and recommendations**

- (i) Despite many decisions on decentralization of resource management at lower levels, the budget allocation of the regional health administration is still being done by the MOHSW.
- (ii) There is a concern that the decentralization concept was not integrated into other ministries' policy decisions. Hence, the MOHSW ended up with deconcentration instead of decentralization.
- (iii) Although the country still maintains that, at the regional level, District Health Management Teams are responsible for the management of health service delivery, two of the country's four regions do not have health administrators.
- (iv) It has been noted that the newly recruited health professionals (and health managers as well) are not sufficiently familiar with the PHC concepts and their role in the delivery of health care. There is therefore a need to revisit PHC policy documentation and revive the work of the various committees with a view to increasing their functionality.

## **TANZANIA**

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

Tanzania's development policy articulated in the National Strategy for Growth and Poverty Reduction (NSGPR) paper has mainstreamed the Millennium Development Goals (MDGs). Considering that most MDGs are health related, and the approach advocated is pro-poor with linkages across sectors encompassing civil society involvement, there is a lot in common with the PHC approach. The Health Sector Strategic Plan focuses on delivery of an essential health interventions package as supported by evidence of cost-effectiveness. Interventions within the essential package cover child, maternal and environmental health in addition to disease management, control and prevention.

Considerable investment in creating a nationwide network of primary facilities has resulted in access by over 90% of the population to a health facility within five kilometres of their residence. Equity of access to health services and equity in distribution of health benefits have remained a challenge particularly judging from the implementation of financing arrangements in an environment where the attained macro-economic stability has not yet trickled down micro-economic benefits to the majority of the population at grassroots.

A mix of selective and comprehensive primary health care is pursued in Tanzania. The focus is the district within the Local Government umbrella. But understanding of PHC varies according to orientation and exposure of the different players in the health field. While some partners see it from a purist district strengthening focus on the basis of pressing priorities, others see it from a holistic angle that includes the support systems. More recently, a new understanding pushing for universal access to basic health care programmed countrywide is being advocated with a political thrust.

### **2. Actions taken to revitalize PHC**

As an integral part of the local government system, PHC gained in terms of local investment with the support of development partners. Local councils are gradually gaining momentum in investing in primary health when gauged from financial contributions to Comprehensive Council Health System Plans. All districts have been trained in planning for health and management of district health. Equity and efficiency in financing are being addressed through the adoption of the

resource allocation formula and cost-effective interventions outlined in the respective comprehensive council health plans. Other aspects of the health system, such as human resources, health information and logistics and supply systems, still call for comprehensive approaches to be strengthened. The use of information and evidence is streamlined and made less burdensome. Data collected at health facility level is used for the purposes of management and planning at that level. The evidence is the comprehensive council health plans. Community involvement has remained excellent in projects but these are faced with the challenge of scaling-up and sustainability. Valuable lessons on empowerment of local communities have emerged from the management of Community Health Funds and the role of facility management committees in providing a voice of the community in the running of health services where health care managers created an enabling environment.

Leadership orientation and support are critical to tapping and maximizing local community potential and shaping the desired future. The nationwide Social Action Fund (TASAF) created opportunities in which multisectoral action for health could be realized. Based on this, the government has initiated a process of increasing health services coverage and enhancing ownership by capitalizing on these experiences. The recently approved primary health services development programme 2007/08-2014/15 will be a key component of the third Health Sector Strategic Plan 2009/10-2012/13 which is currently being formulated.

### **3. Challenges for PHC implementation and recommendations**

- (i) Shortage of qualified human resources as a result of limited investment in the supply system (training), poor distribution, attrition, poor retention and mismanagement. The complementary role of community-based health workers is being revised to accommodate the required changes.
- (ii) Centralization at the district level has left first-line health facilities, communities and households in relative isolation from district health planning and management. However, the implementation of the primary health services development programme (MMAM) will address this issue by decentralizing services as far as to household level.
- (iii) Multisectoral nature of health is an ongoing process that will gradually be realized. Social determinants of health (addressing injustices, violence, inequality and rights) are being articulated and appropriate interventions will soon be instituted.

- (iv) The availability of essential and emergency supplies entails the optimal use of available technology to sound warnings early enough for timely decisions and action. The Ministry of Health and Social Welfare through the Medical Stores Department, has installed an integrated logistical support to address this challenge.
- (v) To improve the quality of health services, the ministry is planning to introduce accreditation systems on a wider scale (build on ADDO, NHI, HIV/AIDS programme experiences).
- (vi) The involvement of lower-level facility managers in health planning and management will be addressed by the planned MMAM programme which will provide an opportunity for the participation of communities and households in the achievement of universal access to basic health care. There is a need to introduce approaches to address social determinants of health at different levels including a new approach to curative services, health promotion, prevention, rehabilitation and reduction of inequity in access and distribution of health benefits.
- (vii) The health profile reveals overall gains in primary health care, which will be consolidated and further improved within the context of the primary health services development programme.

## **TOGO**

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

The country adopted the Alma-Ata Declaration on primary health care (PHC) which is understood as essential health care based on practical and scientifically sound methods and technologies socially acceptable and universally accessible to all individuals, families and communities with their full participation and at affordable cost. Four main PHC principles are identified: team work; accessibility at all times; reliable health information and healthy lifestyles. The Government views PHC as an important strategy for achieving the health millennium development goals by 2015. The country's health policy accords high priority to PHC a strategy for ensuring integrated delivery of promotive, preventive, curative and rehabilitative health care. The five major PHC thrusts outlined in the policy are: reinforcing the national health system; focusing on maternal and child health; prioritizing HIV prevention and treatment/management of

AIDS patients; and reinforcing malaria and TB control. The integration of health services is achieved through the delivery of an essential intervention package.

The country also adopted the Bamako Initiative on community participation in health care financing through cost-recovery schemes. Community contribution to the health budget was 24% in 2004 and 17% in 2005. The communities have set up management and health committees most of which are functional throughout the year (83.6% in 2005).

## **2. Actions taken to revitalize PHC**

The adoption of the Bamako Initiative boosted PHC implementation in the country. Community participation in their own health has increased as well as their contribution to health care financing. A minimum package of activities was also put in place to standardize the delivery of services to the population. The establishment of a PHC directorate within ministry of health with four divisions reinforced the management and monitoring of activities. These divisions are: Family Health; Community Health; Epidemiology; and Public Health and Sanitation. A number of priority programmes were also established at the central level including EPI, Diarrhoeal Diseases, Malaria Control, HIV/AIDS, Tuberculosis, Essential Drugs and other important disease eradication programmes. The availability of essential drugs at health facilities has improved. The elimination of neonatal tetanus, eradication of poliomyelitis, among others, were achieved through national and community efforts.

## **3. Challenges for PHC implementation and recommendations**

- (i) Low access of the population to drinking water (43.0%) and latrines (68.3%). There is a great disparity in drinking water and sanitation coverage in urban and rural areas. The level of poverty is high, reaching 78%. Many newborn babies are underweight. Malnutrition is prevalent in three of the six regions of the country.
- (ii) There is a lack of human resources in the health sector. Available staff has limited experience and skills in health management.
- (iii) Under-financing of the health sector has certain negative impact on the implementation of PHC programmes.
- (iv) There is no national social security system for people living in extreme poverty.
- (v) There is a need to strengthen the health information system in order to have evidence-based data on PHC achievements in the country.

## **UGANDA**

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

PHC is an integral part of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community with the national health system, bringing health care as close as possible to where people live and work. It constitutes the first element of the continuing health care process.

After the Alma-Ata Conference, the implementation of the PHC approach was initiated and was understood as a strategy which would respond more equitably, appropriately and effectively to basic health care needs and also address the underlying social, economic and political causes of poor health. However, the internal turbulence and the breakdown of the health system in the 1970s and 1980s hampered its implementation.

The health sector response to the 1980s and 1990s crisis was to pursue the vertical approach which focused on the prevention and treatment of the few diseases that caused the highest mortality and morbidity and for which there were effective low-cost interventions. This selective PHC operated through vertical structures right up to the community level with community health workers addressing programme-specific community interventions, taking focus away from broader determinants of health - income inequalities, environmental issues, community development, etc. The selective PHC was promoted and received generous funding from external partners (UNICEF, WB). In 1993, the Local Government Act took effect, which promoted the implementation of PHC at community level.

### **2. Actions taken to revitalize PHC**

The national health policy (NHP) was developed in 1999 followed by the health sector strategic plan I and II emphasizing the PHC approach to health care delivery. Features introduced by the government's decentralization policy encompassed devolution of power, responsibilities, authority for decision making and accountability from the centre to the districts. A National Minimum Health Care Package was also defined which outlines interventions that have the highest impact on the morbidity and mortality burden. These initiatives were backed by increased resources to the district health system.

The health system was decentralized along with other sectors as part of the implementation of the Local Government Act 1993, and formed the district health system. The latter was further divided into health sub-districts to ensure more close interaction with the communities. This reorganization implied the transfer of management functions from the centralized bureaucratic system to the client-oriented district health system as well as significant investment in training and developing managerial skills of district managers and other personnel to undertake new responsibilities. In addition, the NHP provided a village health team strategy which is aimed at addressing the main health problems in the community, providing promotive, preventive, curative and rehabilitative services by the team members. A village health team model tested in the Mpigi District of the country clearly demonstrated the huge potential of the decentralized district health system which empowered the district health team to mobilize resources and deliver comprehensive health care to communities. Within the framework of this project, further efforts were put in place to strengthen health facilities, handle referrals as well as sustain the supervision and monitoring of the village health teams.

### **3. Challenges for PHC implementation and recommendations**

- (i) The high level of poverty and inequity coupled with increasing cost of health services and lack of financial resources for health.
- (ii) Emerging verticalization of health interventions resulting from the rise in the number of global health initiatives with a disease focus and aiming to produce quick results may weaken district health systems and affect their sustainability.
- (iii) Increasing health care needs with the rise in noncommunicable diseases, the re-emergence of “old” diseases such as trypanosomiasis, and the high burden of communicable diseases.
- (iv) Inadequate human resources for health and their inequitable distribution; lack of skills of health workers; weak supportive supervision.
- (v) Weak referral system.
- (vi) Weak supply chain and logistics management and technological pressures.
- (vii) Diverse understanding among some stakeholders of what PHC is, coupled with a misconception that it is a cheaper way of delivering health services.

- (viii) Poor coordination of partners involved in field implementation of community-focused activities. There is need to harmonize partner involvement.
- (ix) Lack of sustainable innovative methods for motivating community health workers leading to high drop-out rates and inconsistent involvement in service delivery.

## **ZAMBIA**

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

The Government adopted the PHC approach in 1979 as a means of achieving the goal of health for all by the year 2000 and making essential care universally accessible to individuals and families in the community in an acceptable and affordable way and with their full participation. A PHC unit in the ministry of health was formed in 1983 and committees established at national, provincial, district and health centre levels. Community participation, intersectoral collaboration and overall health system strengthening were identified as key to its success. The focus of PHC activities was on health education, nutrition, water supply and sanitation, immunization, prevention and control of locally endemic diseases, mental health and treatment of common diseases and injuries.

The main successes achieved through the PHC approach were in terms of development of infrastructure and improvement of health indicators. With the deterioration of the national economy in the 1980s, health conditions also worsened: access to health services in terms of quality and quantity declined followed by increased mortality rates, malnutrition, drug shortages, erosion of infrastructure, emerging diseases (HIV/AIDS, TB), loss of public confidence in the health system, declining budget allocation to the health sector, etc. In 1991, the Government reaffirmed its commitment to the PHC strategy in order to attain “Health-for-All” and articulated national health policies and strategies to guide implementation of the health reform with the following PHC-related principles: decentralization and strengthening of planning, budgeting and management capacity, redirection of funds from the centre to districts and communities, providing health care by intervention packages, increasing community involvement and ownership through the establishment of boards and committees.

## **2. Actions taken to revitalize PHC**

The decentralization of health service delivery to districts and hospitals was articulated in the 2001-2005 National Health Strategic Plan (NHSP) accompanied by increased budgetary allocation to health sector reaching 14% in 2001 from 6-7% in the early 1990s. A National Health Services Act was passed in Parliament in 1995 authorizing the creation of a Central Board of Health as an autonomous body under the ministry of health to oversee health service delivery. The decentralization of the governance system was supported by the creation of District Health Management Teams (DHMTs) and District Health Boards (DHBs) that received direct funding from the central level under a basket-funding concept to implement district plans. Technical capacity of the district teams was improved in terms of planning, budgeting and supervision. Current efforts for implementing PHC are guided by the 2006-2011 NHSP.

The sector-wide approach (SWAp) was introduced which increased predictable funding to the sector and accountability through the Financial Accounting and Management System as well as Health Management Information System (HMIS). Intersectoral collaboration has been established at all levels of the health system. National-level partnerships between government, cooperating partners, churches, NGOs and the private sector have improved. At the health centre and district levels there are health centre and neighbourhood committees where community members participate and discuss health issues, contribute to the preparation of annual plans and receive feedback from health workers. At community level, there are community health workers and community-based organizations involved in health activities.

## **3. Challenges for PHC implementation and recommendations**

- (i) The PHC approach is a dynamic process that should be adapted to changing political, economic and environmental contexts, as well as technological advancement.
- (ii) There has to be a strategic refocusing of the core principles of PHC, especially as it is an integral part of the socioeconomic development of the nation.
- (iii) PHC should be holistic with a phased-up approach to its implementation; monitoring and evaluation should be done at critical stages of implementation.
- (iv) PHC has to be delivered within the government reform framework, policies and procedures.
- (v) The health system in general has not been strong enough especially in rural areas. There are also human resource shortages at all levels. Some of the new innovations introduced

in Zambia, such as operationalization of the basic health care package and the construction of health posts to increase accessibility especially in rural areas, have fallen short of expectations.

## **ZIMBABWE**

### **1. The PHC concepts: their understanding and appropriateness to the national context and health policies**

Soon after independence in 1980, the Ministry of Health and Child welfare (MOHCW) outlined a health policy consistent with the economic policy which sought to establish a socialist egalitarian and democratic society for Zimbabwe. The health policy document entitled “Planning for Equity in Health” sought to redress the imbalances in access to health care where the rich enjoyed more sophisticated health care and better health, while the majority - rural based population suffered poor health. Planning for Equity in Health advocated the adoption of the primary health care (PHC) approach whose key components are appropriateness, accessibility, affordability and acceptability of care provided. The PHC approach adopted embodied three basic concepts: the promotion of health depends fundamentally on improving socioeconomic conditions and on the elimination of poverty and underdevelopment; that in this process the people should be both major activists and the main beneficiaries; and that the entire health care system should be restructured to support health activities at the first level which respond to the health needs of the people.

The district was established as the basic planning level for implementation of PHC. The community was actively mobilized through various structures to promote health and the prevention of disease. The reorganization of the health sector to address the inequalities in health care saw significant achievements in health indicators between 1980 and the early 1990s. Unfortunately, the poor macroeconomic environment of the 1990s saw many of these gains being eroded. Despite this, the current national health strategy (1997 – 2007) continues to identify PHC as the cornerstone of health delivery in Zimbabwe. The current strategy acknowledges that improved health cannot be the responsibility of the health sector alone. In the post-independence era, when the economy was still vibrant, the community was actively involved in construction of rural health centers (RHCs), wells and pit latrines which significantly reduced the cost to government. In recent years, however, as people struggle to make ends meet in the harsh macroeconomic environment, community participation for “public goods” has decreased as people struggle to make provisions for their immediate families.

## **2. Actions taken to revitalize PHC**

To implement the PHC approach, the government restructured the fragmented health sector it had inherited at independence. First, priority was given to meeting the urgent health needs of the masses. Priority was also given to providing a package of basic promotive, preventive and rehabilitative activities, accessible to all the people and closely linked with the actions of the community.

The health system was restructured with four distinct functional levels of care, with the higher levels providing support, supervision and referral facilities for the levels below. The RHC level was developed as the first point of contact between the community and the health sector and provided basic but comprehensive promotive, preventive, curative and rehabilitative care. Many new RHCs were built; there are currently over 1,276 RHCs, up from 450 at independence. The primary level refers patients to the district level whose primary function is to support and supervise the RHCs and community health workers. The district is the basic planning unit of the public sector and offers secondary level care. The next is the provincial level providing tertiary care which in turn refers to the quaternary level (central and specialist hospitals). All levels were designed to offer both preventive and curative services.

Due to the high attrition rate among health workers, particularly nurses, the government has introduced a generic health worker called the primary care nurse (PCN). This is a cadre who is trained for 18 months instead of the normal three years for nurse training. The original role of the PCN was primarily care functions so as to free the few trained nurses to continue with nursing functions. In reality, however, these cadres are increasingly manning primary care facilities. Recognizing the high mobility of trained staff from the rural to urban areas, the communities have negotiated with the MOHCW to be involved in selecting candidates for the PCN programme from within their communities. The community identifies qualified candidates whose applications are endorsed by the local community leaders. For now, this has worked well as the candidates are committed to their communities and therefore more likely to stay in post for a longer period providing stability at RHCs.

### **3. Challenges for PHC implementation and recommendations**

- (i) In theory, patients are required to present initially at the primary level, then progressively referred to secondary and eventually to quaternary level depending on the complexity of the illness. In practice, however, especially over the last few years, the system has witnessed a breakdown in the referral chain, with central hospitals often now functioning as first care facilities – a gross misuse of resources. The reasons for this break in the referral chain are varied, but include, among others, the deterioration in the quality of services especially primary care services due to rapid expansion without the necessary increased investment in health.
- (ii) Despite government's commitment to redress the inequities inherited from the colonial era, these still exist. Although the budget for the health sector has continued to increase in dollar terms, in real terms the value has decreased, therefore effective implementation of PHC has been hampered.
- (iii) Poverty levels have continued to escalate - the proportion of people below the poverty line increased from 29% in 1995 to 58% in 2003 (PASS) while the proportion of people below the Total Consumption Poverty line (very poor and poor) increased from 55% in 1995 to 72% in 2003. This has negatively impacted on community involvement – communities are too busy trying to secure food.
- (iv) Zimbabwe has not been spared by the human resources for health crisis currently faced by other countries in the region. Successful implementation of PHC was prefaced on the assumption that the health workers would be available to lead this process.
- (v) The HIV pandemic has also further strained the health sector. Systems that were functional have been strained and as a result are not able to respond to the needs of the communities. A large number of new players have entered the health sector to find weakened systems and have tried to respond to this by setting up parallel structures that have not helped the system.